Supplement to Manual on Addressing AODA in Partnership Program

Center for Excellence in Long-Term Care
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Supplement to Training Manual on Addressing AODA in Partnership Program

This Supplement to the Manual on Addressing Alcohol and Other Drug Problems in the Partnership Program provides additional optional documents for those who would like more detailed information. Extensive information is now available on the Internet. Information on medications used to treat AOD should be sought there or other sources to ensure that it is up to date.

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Baseline Data on AODA Costs in the Wisconsin Partnership Program

Preliminary Findings-To-Date, October 20, 2003

Staff from the Center for Delivery Systems Development (CDSD staff) worked with each of the Partnership organizations to identify Partnership members who had AODA problems. Partnership members were placed in one of four groups for comparison purposes:

- Group B: Member has an AODA diagnosis either from Partnership records, Medicaid fee-for-service claims, or encounter data while in the Partnership program, and is not known to be in recovery;
- Group C: Partnership team "suspects" that there is a problem with alcohol or drug abuse;
- Group AR: Member describes him/herself as being in recovery, and
- Group A: Member does not have an AODA diagnosis and the team does not "suspect" problems with alcohol or drugs.

A list of AODA and mental illness diagnoses is attached.

The total population in this study is 1,178 Partnership members who were enrolled as of October 2002. The table below shows the number of people in each study group by Partnership site.

Table 1: Number of People in Each Study Group by Partnership Site

Organization	Target Group	B: AODA Dx	C:"Suspected" Users	AR: In Recovery	A: No AODA Dx	Grand Total
CCE	Frail Elderly	18	0	15	214	247
CHP	Frail Elderly	10	15	9	217	251
CHP	Physically Disabled	11	8	7	66	92
CLA	Physically Disabled	23	7	30	148	208
Elder Care	Frail Elderly	36	0	21	323	380
Grand Total		98	30	82	968	1,178
% of People in each Group		8.3%	2.5%	7.0%	82.2%	100.0%

CDSD staff compared the aggregate inpatient hospital and nursing home utilization from 1998-2002. The data was aggregated into a five-year period in order to see overall differences. On an annual basis, the data fluctuates dramatically because of the relatively small number of people in each study group. (See page 3 for annual comparison data.)

Staff conducted Pearson's chi-square tests for statistical significance of the proportion of people in each group who had any hospitalization during the 5-year period while in the Medicaid fee-for-service system or in the Partnership Program. A "yes-yes" distinction in the table meant that the person has an AODA diagnosis and was hospitalized at least one time during the 5-year time period. A "no-no" distinction meant that the person does not have an AODA diagnosis and was not hospitalized during the 5-year time period.

		Hospitalized During 5-Year Time Period?		
		Yes	**No**	**Totals**
Have an AODA Diagnosis ?	**Yes**	**75**	**23**	**98**
	No	**592**	**376**	**968**
	Totals	**667**	**399**	**1,066***

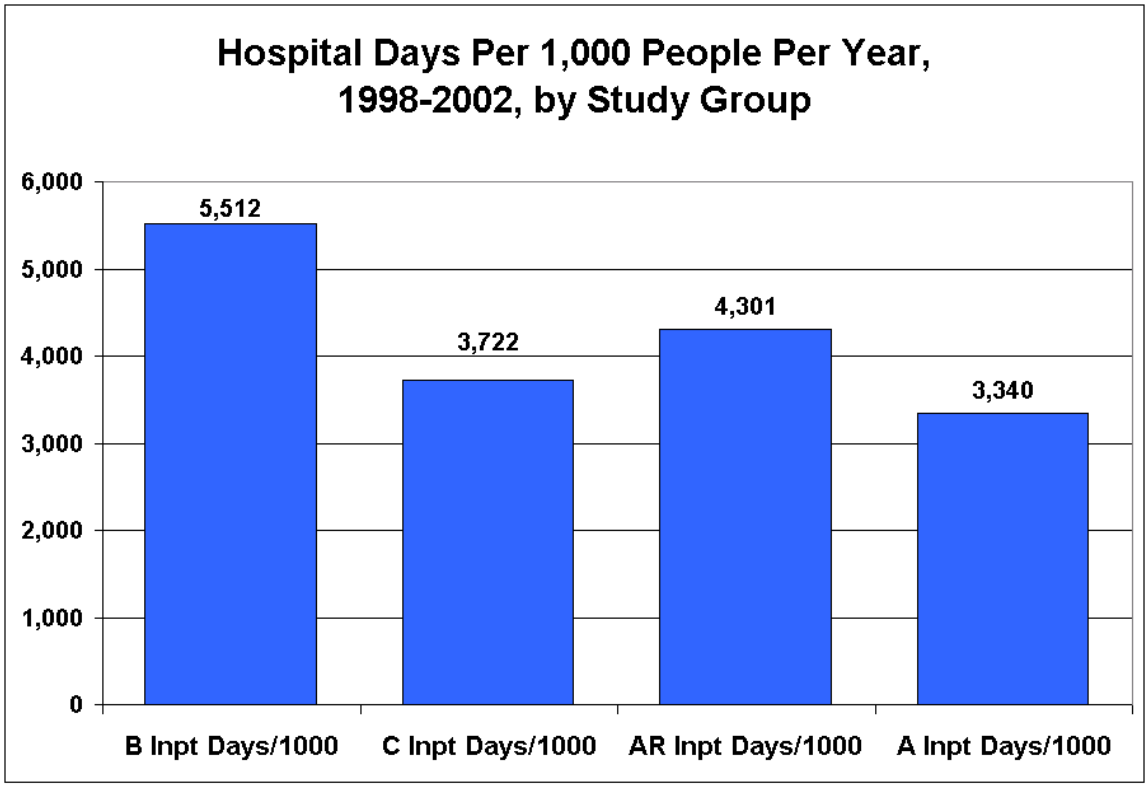
*The chi-square test compares two of the four groups, thus the number of 1,066 differs from that of the total population. The chi-square test yielded a statistic of 8.98 with one degree of freedom. This statistic means that the probability of the above hospitalization pattern occurring by chance is less than 1%, which is statistically very significant. The chi-square test was also done to compare hospitalizations of the following groups:

1) Recovery group with the non-AODA group (chi-square of 2.24, <30% likelihood of happening by chance);
2) AODA group with the recovery group (chi-square of 1.12, <30% likelihood of happening by chance).

The final three comparisons had no statistical significance and a likelihood of happening by chance about 50% of the time.

3) Suspect group with the non-AODA group;
4) Suspect group with the those having an AODA diagnosis, and
5) Nursing home stays of the AODA group with the non-AODA group.

The graphs on the next page display the inpatient hospital and nursing home utilization by comparison group. There is a significantly higher use of inpatient and nursing home care by Group B, those with an AODA diagnosis. Those in recovery and those "suspected" of AODA abuse use more hospital days than the non-AODA group. Nursing home use shows little variation between the recovery, "suspected", and non-AODA groups.


Hospital Days Per 1,000 People Per Year,
1998-2002, by Study Group
6,000
5,000
4,000
3,000
2,000
1,000
0
5,512
3,722
4,301
3,340
B Inpt Days/1000
C Inpt Days/1000
AR Inpt Days/1000
A Inpt Days/1000

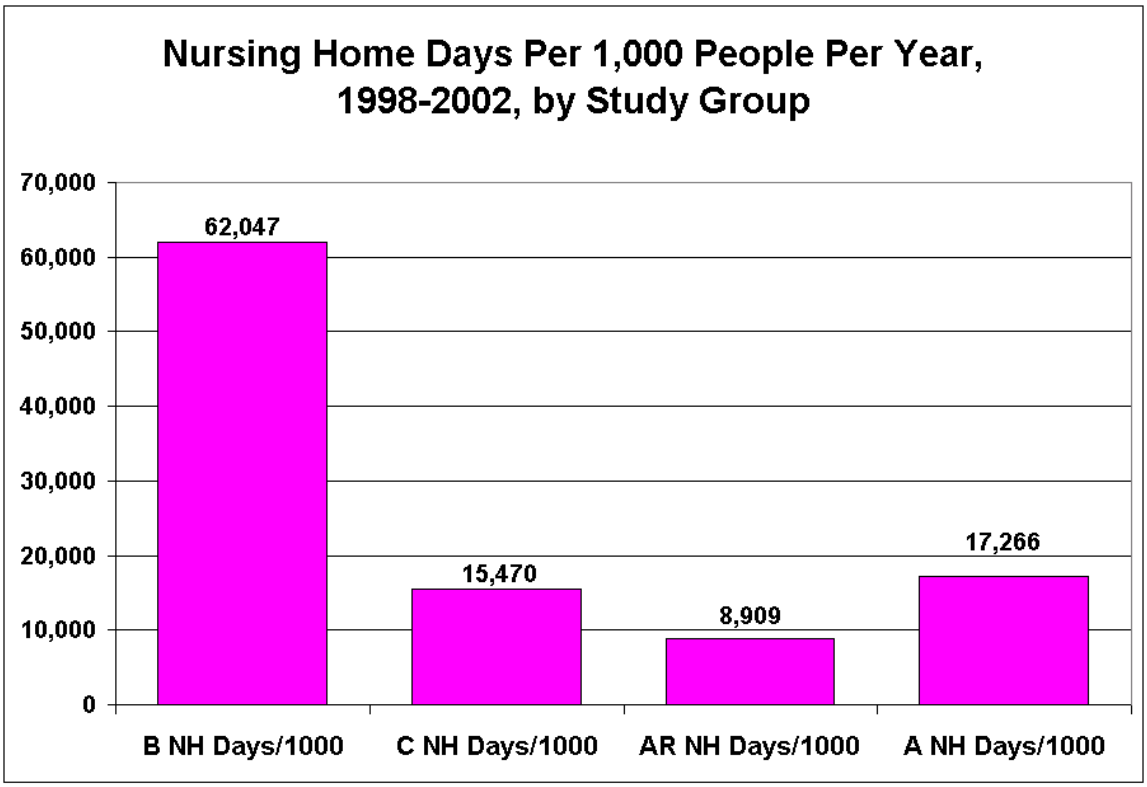

Nursing Home Days Per 1,000 People Per Year,
1998-2002, by Study Group
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
62,047
15,470
8,909
17,266
B NH Days/1000
C NH Days/1000
AR NH Days/1000
A NH Days/1000

Table 2: Utilization Summary

Utilization Summary by AODA Group, 1998-2002, Includes Medicaid Fee-For-Service & Partnership

Year	B Group Member Months	B Group Inpatient Days	B Group NH Days	B Inpatient Days/1000	B NH Days/1000
1998	492.4	196.0	237.0	4,776.6	5,775.8
1999	416.9	242.0	241.0	6,965.7	6,936.9
2000	978.5	438.0	4,137.0	5,371.5	50,734.8
2001	1,067.7	573.0	8,132.0	6,440.0	91,396.5
2002	1,074.4	402.0	8,090.0	4,489.9	90,357.4
Grand Total	4,029.9	1,851.0	20,837.0	5,511.8	62,047.2

Year	C Group Member Months	C Group Inpatient Days	C Group NH Days	C Inpatient Days/1000	C NH Days/1000
1998	159.0	41.0	58.0	3,094.3	4,377.4
1999	94.5	49.0	102.0	6,222.2	12,952.4
2000	331.5	39.0	29.0	1,411.8	1,049.8
2001	346.9	200.0	650.0	6,918.4	22,484.9
2002	348.0	68.0	811.0	2,344.8	27,965.5
Grand Total	1,279.9	397.0	1,650.0	3,722.2	15,470.0

Year	AR Group Member Months	AR Group Inpatient Days	AR Group NH Days	AR Inpatient Days/1000	AR NH Days/1000
1998	400.5	81.0	17.0	2,427.0	509.4
1999	352.1	298.0	42.0	10,156.2	1,431.4
2000	832.7	250.0	407.0	3,602.7	5,865.3
2001	896.0	279.0	1,174.0	3,736.6	15,723.2
2002	961.4	326.0	916.0	4,069.1	11,433.3
Grand Total	3,442.7	1,234.0	2,556.0	4,301.3	8,909.3

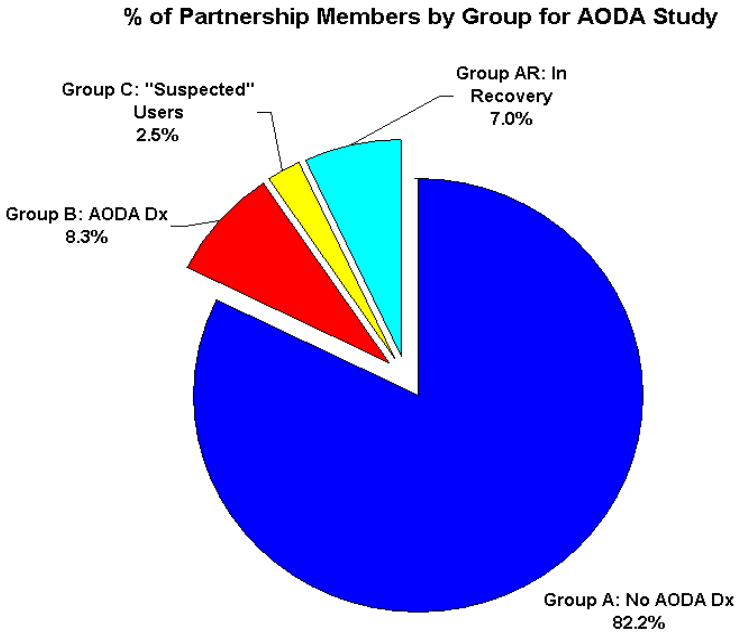
Year	A Group Member Months	A Group Inpatient Days	A Group NH Days	A Inpatient Days/1000	A NH Days/1000
1998	3,818.0	1,065.0	3,400.0	3,347.3	10,686.2
1999	3,385.3	901.0	3,388.0	3,193.8	12,009.6
2000	9,362.9	2,606.0	8,137.0	3,340.0	10,428.8
2001	10,675.9	3,737.0	19,915.0	4,200.5	22,385.0
2002	10,438.0	2,178.0	19,374.0	2,503.9	22,273.2
Grand Total	37,680.1	10,487.0	54,214.0	3,339.8	17,265.6

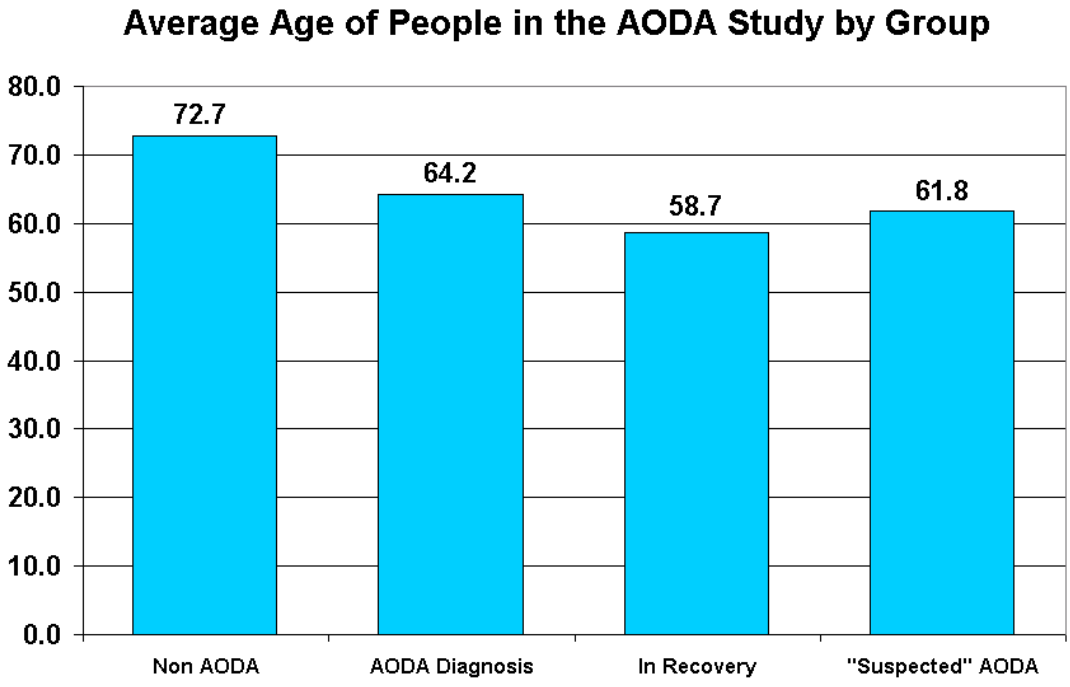
	Total Member Months	FTE
1998	**4,869.9**	**405.8**
1999	**4,248.8**	**354.1**
2000	**11,505.6**	**958.8**
2001	**12,986.5**	**1,082.2**
2002	**12,821.8**	**1,068.5**

Group Definitions

B Group have an AODA diagnosis.
C Group are "suspected" AODA dependent.
AR Group are in recovery.
A Group are not AODA dependent or "suspected".

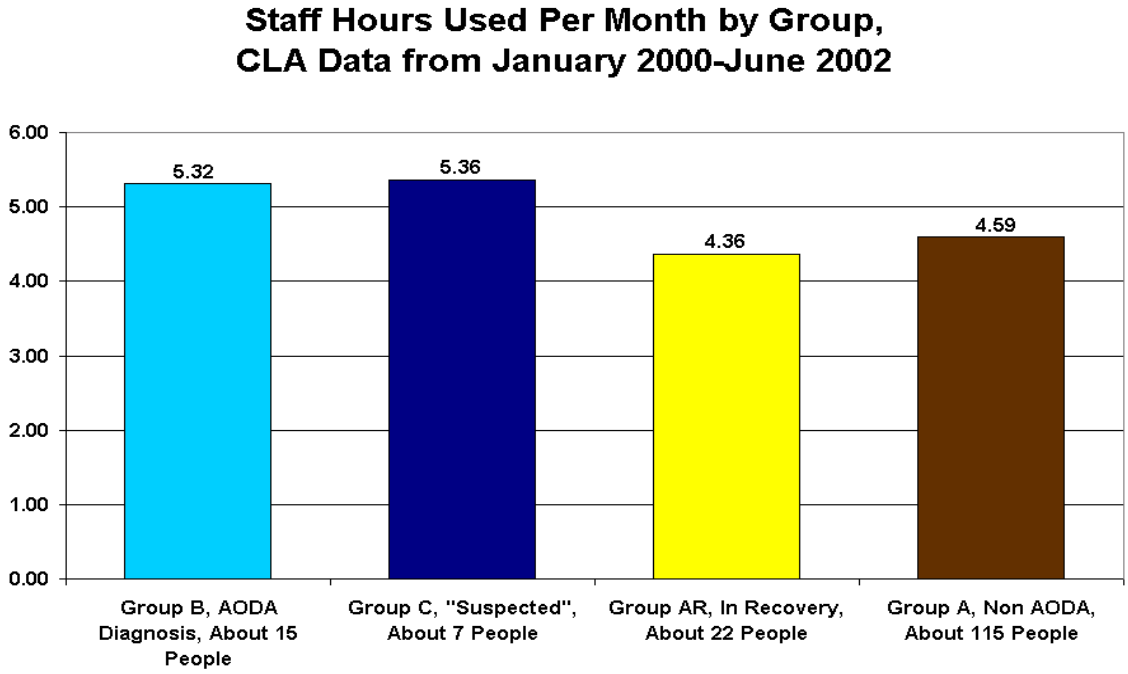
These pie charts illustrate Partnership members in aggregate and the Partnership organizations with the greatest and least proportion of people affected by AODA. Interestingly, two of the Partnership organizations identified no members as being "suspected" AODA users.



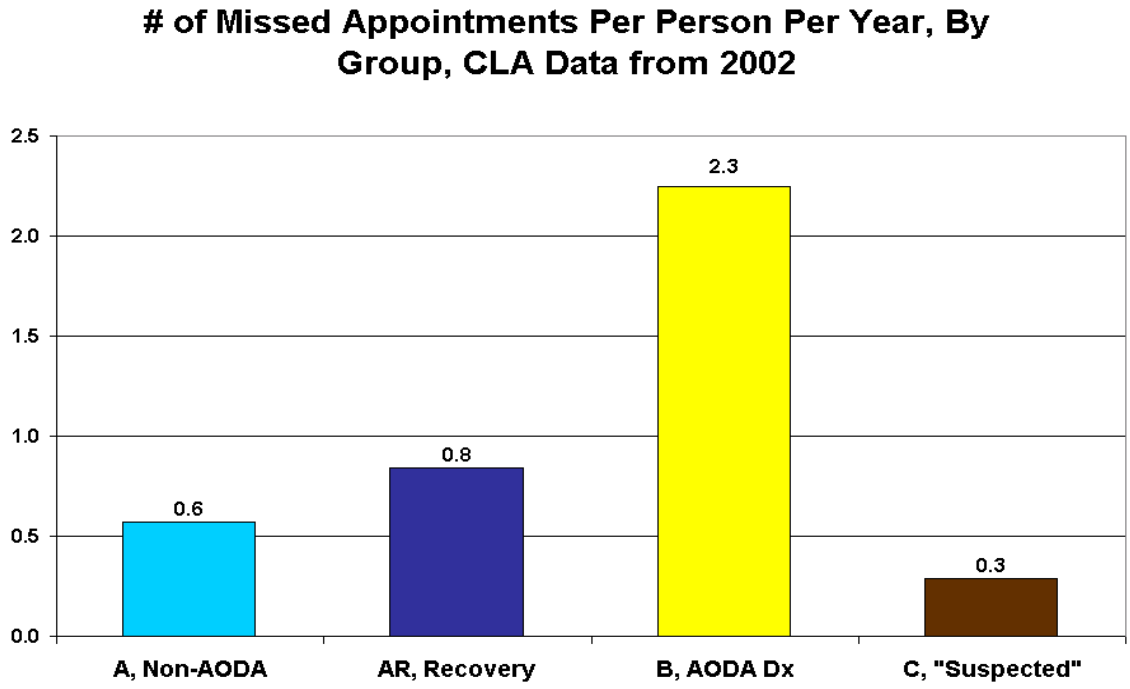


CLA had detailed data about the type and duration of staff resources used by the members in their program. The following chart displays the average number of staff hours used by the different groups in this study for the time period of January 2000 through June 2002.

This next chart shows a notable difference in the number of missed appointments for January



through June 2002 (only data available for this event) by the study groups.



In summary:

1) There are significant differences in utilization:

a) The B group, those with an AODA diagnosis, has averaged 5,512 hospital days per 1,000 people per year (days per 1,000) compared to 3,340 days per 1,000 for the A group, those without an AODA diagnosis;
b) The B group has averaged 62,047 nursing home days per 1,000 compared to 17,266 days per 1,000 for the A group;
c) The average age of all Partnership members is 71.8. The group with an AODA diagnosis has an average age of 64.2 yet has the highest utilization. Those without an AODA diagnosis are the oldest group with an average age of 72.7 and have the lowest inpatient utilization of all groups and

2) The B group, those with an AODA diagnosis, have significantly more missed appointments, and use more staff resources than the other study groups.

3) Those in groups AR and C, those in recovery and "suspected users", have greater utilization of inpatient care than those without an AODA diagnosis.

This study provides a baseline of utilization of staff resources and certain health care services. The differences help to emphasize the importance of staff identification and intervention for those with an AODA problem.

Cognitive-Behavioral Therapy

A Brief Overview

Summarized from SAMHSA TIP 34: Brief Interventions and Brief Therapies for Substance Abuse

"Cognitive behavioral therapy" generally refers to psychological theories that what we think affects how we feel: Our thoughts influence, even cause, our feelings, which often drive our behaviors. If we change our thoughts, we can change our feelings and behaviors.

Many of us have dysfunctional thought patterns: unrecognized assumptions, automatic thoughts, negative self-statements, unexamined beliefs. Such distorted thinking patterns are common in many people, and are especially prominent in depression, personality disorders, anxiety, anorexia, and substance use problems. For example,

- Depressed people are extremely self-critical, blame themselves for everything, think themselves unworthy of living, think life is all bad and hopeless, etc.
- Incest survivors with post-trauma/ borderline personality think themselves unlovable, and expect exploitation and abandonment from others.

We often use alcohol or drugs to drown out some of these unpleasant thoughts, and, in addition, people with AOD problems have thought distortions around blame and responsibility and feeling doomed and mistreated.

On the next page are some of the most common thought distortions, also called irrational thoughts.

IRRATIONAL THINKING

All-or- Nothing Thinking Also called **Polarized thinking** **"Black & white" thinking**	**Thinking of everything in extremes, with no middle ground.** *That always happens. You never listen to me. You always do that.* *It's hopeless. I can't do it. Life stinks.*
Emotional Reasoning	**Thinking that because you feel it, it must be true.** *I feel frightened , so they must frightening.* *I feel angry, so he must have done something wrong.*
Mind-reading also called **Future-telling** **Jumping to Conclusions**	**Assuming one's negative interpretations are true without checking out the facts. Thinking you can read people's minds.** *She doesn't like me. They all think I'm stupid.* *He did that on purpose.* *It will fail.*
Labeling	**Discounting an entire person by labeling them (or oneself):** *I'm a loser. I'm hopeless.* *He's an idiot. He's nothing but a drunk.*
Filtering Also called **Negativizing** and **Minimizing the positive**	**Dwelling on one negative detail, ignoring all the positive aspects.**
Discounting the Positive	**Disqualifying positive experiences as "not counting" for various reasons.** *You're just saying that to be nice.*
Blaming/ Shaming Also called **Control Fallacy**	**Blaming oneself for negative event one is not responsible for. Blaming others for one's pain or situation.**
Should statements	**"Having a list of ironclad rules about how you and others people "should" act; becoming angry at people who break the rules and feeling guilty if you violate the rules" (1)**, p. 63 *I should have done that. I'm not supposed to do this. I should be that way.*
Fallacy of fairness	**"Feeling resentful because you think you know what is fair, even though other people do not agree"** (ibid)
Being right	**Always needing to prove you're right and others are wrong; being afraid of being wrong.**
Martyrdom Fallacy	**"Expecting all sacrifice and self-denial to pay off, as if there were someone keeping score, and feeling disappointed and even bitter when the reward does not come."** (ibid)
Personalization **"**	"Thinking that everything people say or do is some kind of reaction to you; comparing yourself to others, trying to determine who's smarter or better looking" (ibid)

As you can see, these distorted thought patterns are common to many, many people, not just those with diagnoses! They are also called "automatic" thoughts because they're so engrained ("overlearned") that the individual thinks they are reality. What can you do with them in your work?

- Listen for distorted thinking.
- Depending on the situation, the person, your relationship, and how they're said:
  - Provide **F**eedback on these distortions.
    Be gentle and subtle with this, to avoid arguing or criticizing
    Suggest alternative ways to think about it
    As person has more practice, ask them how else they could think about it

Distorted or Irrational Thoughts Common Among People with AODA

The distorted thoughts common to many people are common among people with AODA as well. Many people with AODA have very low tolerance for feeling uncomfortable emotions. This is called "discomfort anxiety." They often tend to have low tolerance for frustration. Some have high need for excitement, stimulation, or gratification. Almost all (despite bravado) have high levels of self-blame, guilt, and shame for being an addict.

Interestingly, "a negative view of the self as a person with a substance abuse problem" only worsens these thought distortions for many people (1, p 63). Phrases like "in denial" and "lacks insight" tend to be similarly insulting to people who probably already have too much negative self-regard. This is why empathic engagement can be so helpful. Also, you are **modeling** a trustworthy and supportive relationship.

From SAMHSA TIP 34

Common Irrational Beliefs About Alcohol and Drugs With More Rational Alternatives	
Irrational Belief	**Rational Alternative or Dispute**
I need to use drugs to relax.	I want to use drugs but don't have to use them just because I want to.
I can't stand not having what I want; it is just too hard to tolerate.	I may not like it, but I have stood it in the past and can do so now.
The only time I feel comfortable is when I'm high.	It's hard to learn to be comfortable socially without drugs but people do so all the time.
It would be too hard to stop drinking. I'd lose all my friends, be bored, and never be comfortable without it.	While stopping drinking and doing drugs might cot me some things and take time and effort, if I don't, the consequences will be far worse.
People who can't or don't drink are doomed to frustration and unhappiness.	Where's the evidence of that?" I'll try going to an AA meeting and do some research on how miserable these nondrinkers actually are.
Once you've stopped using and you see it's all over, you're right back to where you started, and all your efforts only lead you to total failure. Once an addict, always an addict.	A slip is only a new learning experience toward recovery. It is not a failure, only a setback that can tell me what direction I need to go in now. It's my choice.

Source: SAMSHA TIP 34, pg. 65 (Adapted from Rotgers,1996)

Another very common thought pattern that includes many of the above tendencies is the **"victim—perpetrator—rescuer triangle."** Many people have a tendency, usually ingrained since early childhood, to perceive interactions as having these three roles. People with complex post-traumatic stress disorder (from childhood abuse) and/or those labeled with borderline personality disorders often think in terms of the victim-perpetrator-rescuer triangle. At first, they tend to idealize another as a rescuer, but eventually behave in ways that make themselves the victims of us as perpetrators. People with antisocial personality disorder tend to see themselves as victims and everything and everyone else as blameworthy. One part of this is that people often perceive themselves as helpless victims of external forces—their addictions, other people, life's hardships—and of internal forces—their emotions and thoughts. This is why empowering them (as in all the FRAMES steps and in motivational enhancement) is so critical:

SOURCE: http://www.drugabuse.gov/NIDAHome.html

Commonly Abused Drugs

Substance: Category and Name	Examples of *Commercial* and Street Names	Schedule*/How Taken	*Intoxication Effects*/Potential Health Consequences
Cannabinoids			*Euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination* Cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety; panic attacks; tolerance, addiction
Hashish	Boom, chronic, gangster, hash, hash oil, hemp	I/swallowed, smoked	
Marijuana	Blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I/swallowed, smoked	
Depressants			*Reduced pain and anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration*/confusion, fatigue; impaired coordination, memory, judgment; respiratory depression and arrest, addiction *Also, for barbiturates—sedation, drowsiness*/depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness *for benzodiazepines—sedation, drowsiness*/dizziness *for flunitrazepam*—visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects *for GHB*—drowsiness, nausea/vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death *for methaqualone—euphoria*/depression, poor reflexes, slurred speech, coma
Barbiturates	*Amytal, Nembutal, Seconal, Phenobarbital;* barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V/injected, swallowed	
Benzodiazepines (other than flunitrazepam)	*Ativan, Halcion, Librium, Valium, Xanax;* candy, downers, sleeping pills, tranks	IV/swallowed	
Flunitrazepam***	*Rohypnol;* forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	
GHB***	*Gamma-hydroxybutyrate;* G, Georgia home boy, grievous bodily harm, liquid ecstasy	Under consideration/swallowed	
Methaqualone	*Quaalude, Sopor, Parest;* ludes, mandrex, quad, quay	I/injected, swallowed	
Dissociative Anesthetics			*Increased heart rate and blood pressure, impaired motor function*/memory loss; numbness; nausea/vomiting *Also, for ketamine—at high doses, delirium, depression, respiratory depression and arrest* *for PCP and analogs—possible decrease in blood pressure and heart rate, panic, aggression, violence*/loss of appetite, depression
Ketamine	*Ketalar SV;* cat Valiums, K, Special K, vitamin K	III/injected, snorted, smoked	
PCP and analogs	*Phencyclidine;* angel dust, boat, hog, love boat, peace pill	I, II/injected, swallowed, smoked	

Substance: Category and Name	Examples of *Commercial* and Street Names	Schedule*/How Taken	*Intoxication Effects*/Potential Health Consequences
Hallucinogens			*Altered states of perception and feeling; nausea*/chronic mental disorders, persisting perception disorder (flashbacks) *Also, for LSD and mescaline—increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors* *for psilocybin—nervousness, paranoia*
LSD	*Lysergic acid diethylamide;* acid, blotter, boomers, cubes, microdot, yellow sunshines	I/swallowed, absorbed through mouth tissues	
Mescaline	Buttons, cactus, mesc, peyote	I/swallowed, smoked	
Psilocybin	Magic mushroom, purple passion, shrooms	I/swallowed	
Opioids and Morphine Derivatives			*Pain relief, euphoria, drowsiness*/respiratory depression and arrest, nausea, confusion, constipation, sedation, unconsciousness, coma, tolerance, addiction *Also, for codeine—less analgesia, sedation, and respiratory depression than morphine* *for heroin—staggering gait*
Codeine	*Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine;* Captain Cody, Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV/injected, swallowed	
Fentanyl	*Actiq, Duragesic, Sublimaze;* Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	II/injected, smoked, snorted	
Heroin	*Diacetylmorphine;* brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I/injected, smoked, snorted	
Morphine	*Roxanol, Duramorph;* M, Miss Emma, monkey, white stuff	II, III/injected, swallowed, smoked	
Opium	*Laudanum, paregoric;* big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	
Stimulants			*Increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness*/rapid or irregular heart beat; reduced appetite, weight loss, heart failure *Also, for amphetamine—rapid breathing; hallucinations*/tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction *for cocaine—increased temperature*/chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition *for MDMA—mild hallucinogenic effects, increased tactile sensitivity, empathic feelings, hyperthermia*/impaired memory and learning *for methamphetamine—aggression, violence, psychotic behavior*/memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction *for methylphenidate—increase*
Amphetamine	*Adderall, Biphetamine, Dexedrine;* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swallowed, smoked, snorted	
Cocaine	*Cocaine hydrochloride;* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/injected, smoked, snorted	
MDMA (methylenedioxy-methamphetamine)	*DOB, DOM, MDA;* Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I/swallowed	
Methamphetamine	*Desoxyn;* chalk, crank, crystal, fire, glass, go fast, ice, meth, speed	II/injected, swallowed, smoked, snorted	
Methylphenidate	*Ritalin;* JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II/injected, swallowed, snorted	

Substance: Category and Name	Examples of *Commercial* and Street Names	Schedule*/How Taken	*Intoxication Effects*/Potential Health Consequences
Nicotine	Bidis, chew, cigars, cigarettes, smokeless tobacco, snuff, spit tobacco	Not scheduled/smoked, snorted, taken in snuff and spit tobacco	
Other Compounds			
Anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise;* roids, juice	III/injected, swallowed, applied to skin	*No intoxication effects*/hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics
Inhalants	*Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl);* laughing gas, poppers, snappers, whippets	Not scheduled/inhaled through nose or mouth	*Stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing*/unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death

*Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Most Schedule V drugs are available over the counter.

**Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.

***Associated with sexual assaults.

FROM http://www.drugabuse.gov/NIDAHome.html

AODA Rates

Excerpted from http://www.recoverymonth.gov/2002/kit/

Current Facts about Drug and Alcohol Use and Addiction in the U.S.

Illicit Drugs[11]

- An estimated 14 million Americans (6.3 percent of the population 12 and older) were current users of illicit drugs in 2000, meaning they had used an illicit drug at least once during the 30 days prior to being interviewed. Illicit drug use among youth was highest for those between the ages of 18 and 20 (19.6 percent) in 2000. As in prior years, men continued to have a higher rate of current illicit drug use than women in 2000 (7.7 percent vs. 5 percent). However, the rates of nonmedical use of psychotherapeutic prescription drugs were comparable (1.8 percent vs. 1.7 percent). The rates of current illicit drug use for major racial/ethnic groups in 2000 were: 6.4 percent for whites, 5.3 percent for Hispanics, and 6.4 percent for African-Americans. Rates were highest among American Indian/Alaska Natives (12.6 percent) and persons of multiple race (14.8 percent). Asian/Pacific Islanders had the lowest rates (2.7 percent).[12] Overall illicit drug use among teens remained steady in 2000. However, the use of Ecstasy (MDMA), steroids, and heroin (without using a needle) increased noticeably.[13]

Prescription Drugs

- Several leading indicators suggest that prescription drug addiction is on the rise in the U.S. In 1998, an estimated 1.6 million Americans used prescription pain relievers non-medically for the first time, a significant increase from the 1980s when there were generally less than 500,000 first-time users per year. From 1990 to 1998, the number of new users of prescription pain relievers increased by 181 percent; of tranquilizers by 132 percent; of sedatives by 90 percent; and of stimulants 165 percent.[14]

- Of the 5.7 million users of illicit drugs other than marijuana, 3.8 million were using psychotherapeutics non-medically in 2000. Psychotherapeutics include pain relievers (2.8 million users), tranquilizers (1 million users), stimulants (0.8 million users), and sedatives (0.2 million users).[15] The three classes of prescription drugs that are most commonly abused are opioids, which are most often prescribed to treat pain; central nervous system (CNS) depressants, which are used to treat anxiety and sleep disorders; and stimulants that are prescribed to treat the sleep disorder narcolepsy, attention-deficit hyperactivity (ADHD), and obesity.[16] Alcohol and prescription drug misuse affects up to 17 percent of older adults. As the average American continues to live longer, substance abuse among adults 60 and older is becoming one of the fastest growing health problems facing the country.[18]

Alcohol and Tobacco

- 12.6 million Americans aged 12 and older were heavy drinkers (five or more drinks at one occasion on at least five different days in the past 30 days), and approximately one-fifth (20.6 percent) of them participated in binge drinking (five or more drinks on one occasion at least once in the 30 days prior to survey).[19]

- In 2000, the illegal use of alcohol among teens was extremely widespread. About 27.5 percent, or 9.7 million young people between the ages of 12 and 20, reported drinking alcohol in the month prior to being surveyed. Of these, 6.6 million (18.7 percent) were binge drinkers and 2.1 million (6.0 percent) were heavy drinkers.[20] Sixty-two percent of 12th graders and 25 percent of 8th graders reported they had been drunk at least once.[21] Whites were more likely than any other race/ethnicity group to report current use of alcohol in 2000 (50.7 percent reported past month use). The next highest rates were for persons identified as mixed race (41.6 percent) and Hispanics (39.8 percent). The lowest current

drinking rates were observed for Asian/Pacific Islanders (28 percent) followed by African Americans at 33.7 percent and American Indian/Alaska Natives at 35.1 percent.[22] A little over 29 percent of the American population aged 12 and older, or 65.5 million people, reported they used some form of tobacco in the past 30 days.[23]

Other Important Information Regarding Specific Illicit Drugs

Cocaine/Crack

- Cocaine is a powerfully addictive stimulant that directly affects the brain. It is generally sold on the street as a fine, white, crystalline powder, known as coke, C, snow, flake, or blow.[25] Crack is the street name given to the freebase form of cocaine that is processed from the powdered cocaine hydrochloride form to a smokable substance. It produces an immediate, euphoric high and is also inexpensive to produce and buy.[26] The long-term effects of cocaine include: addiction, irritability and mood disturbances, restlessness, paranoia, and auditory hallucination's. The medical consequences of cocaine abuse include: disturbances in heart rhythm, heart attacks, chest pain, respiratory failure, strokes, seizures and headaches, abdominal pain, and nausea.[27]

Hallucinogens

- Hallucinogens include LSD (lysergic acid diethylamide, also known as acid, blotter, boomers, cubes, microdot, or yellow sunshines), mescaline (also known as buttons, cactus, mesc, or peyote), and psilocybin (also known as magic mushroom, purple passion, or shrooms).[28] Under the influence of hallucinogens, the sense of direction, distance, and time become disoriented. These drugs can produce unpredictable, erratic, and violent behavior in users that sometimes leads to serious injuries and death. The long-term effects from using hallucinogens vary by individual; however, some common physical effects of using hallucinogens include increased heart rate and blood pressure; decreased awareness of touch and pain that can result in self-inflicted injuries; convulsions; coma; and heart and lung failure. Psychological effects include depression, anxiety, and paranoia; violent behavior; and persisting perception disorder (flashbacks).[29]

Heroin

- Heroin is the most abused and rapidly acting of the opiate class of drugs, and is highly addictive. It is typically sold as a white or brownish powder or as a black, sticky substance known on the streets as "black tar heroin."[30] The long-term effects of heroin abuse include: addiction, substantially increased risk of infectious diseases such as HIV/AIDS and hepatitis B and C due to intravenous use or risky sexual behaviors, collapsed veins, bacterial infections, abscesses, infection of heart lining and valves, and arthritis and other rheumatologic problems. Because most street heroin is "cut" with other drugs or substances, users do not always know the strength of the drug or what is in it. As a result, they are at increased risk of overdose or death.[31]

Methamphetamine[33]

- Methamphetamine and amphetamine use has been on the rise since 1994. Methamphetamine is a powerfully addictive stimulant associated with serious health conditions, such as memory loss, aggression, psychotic behavior, heart and brain damage, and increased risk of sexual behavior, which contributes to contracting hepatitis and HIV/AIDS.[34]

MDMA or Ecstasy

- Ecstasy is a stimulant, a so-called "club drug" because of its popularity with young people at night clubs and "raves."[35] In 2000, Ecstasy use increased at all three grade levels studied (8th, 10th and 12th). Its use is now more prevalent among American teens than cocaine use, and reported availability of the drug continues to increase sharply.[36] Side effects and health consequences of Ecstasy use include: increased heart rate, blood pressure and metabolism; feelings of exhilaration, energy, and increased mental alertness/rapid or irregular heart beat; reduced appetite, weight loss, dehydration, heart failure; mild hallucinogenic effects; and impaired memory and learning.[37] Using Ecstasy can result in death for first-time users as well as habitual users.

Important Information Regarding Other Misused and Potentially Addictive Substances

Inhalants

- Inhalants are volatile substances that produce chemical vapors that can be inhaled to induce a psychoactive, or mind-altering, effect.[38] They include solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexl), laughing gas, poppers, snappers, and whippets.[39] Inhalants are the only class of drugs that tend to be more popular among younger teens than among older ones. Annual prevalence rates for 8th, 10th, and 12th graders in 2000 were 9 percent, 7 percent, and 6 percent respectively.[40] Signs of inhalant abuse include: chemical odors on breath or clothing; paint or other stains on face, hands, or clothes; hidden empty spray paint or solvent containers and chemical-soaked rags or clothing; drunk or disoriented appearance; slurred speech, nausea, or loss of appetite; inattentiveness, lack of coordination, irritability, or depression; and sudden death, which can happen to novice or habitual users.[41]

Steroids

- "Anabolic steroids" is the familiar name for synthetic substances related to the male sex hormones (androgens). They promote the growth of skeletal muscle (anabolic effects) and the development of male sex characteristics (androgenic effects).[42] Steroid use among younger male teens increased sharply in 1999, and continued to rise among 10th grade boys in 2000. Use held steady in the other two grades studied (8th and 12th) in 2000.[43] Steroids can be taken orally, as well as by injection. The possible health consequences associated with their use include: infertility, breast development, and shrinking of the testicles in males; baldness; short stature; tendon rupture; heart attacks or enlargement of the heart's left ventricle; cancer and certain kinds of hepatitis; acne and cysts; HIV/AIDS; and disturbing psychiatric effects, such as homicidal rage, mania, and delusions.[44]

Ritalin

Methylphenidate, also known as Ritalin, JIF, MPH, R-ball, Skippy, the smart drug, and vitamin R, is a schedule II drug with high potential for abuse. It can be injected, swallowed, or snorted, and can cause an increase or decrease in blood pressure, psychotic episodes, digestive problems, loss of appetite, and weight loss.[45] Ritalin abuse may be increasing. Eight sites in the National Institute on Drug Abuse's most recent Community Epidemiology Work Group reported its abuse, primarily among youth who crush and snort tablets. Ritalin is also being injected, sometimes with heroin or heroin and cocaine.[46]

Excerpted from http://www.recoverymonth.gov/2002/kit/

AODA Internet Resources

Information for Practitioners

http://www.dhfs.state.wi.us/substabuse/Education/Teleconference/Materials2.htm
HIGHLY recommended. The Wisconsin Bureau of Mental Health and Substance Abuse Services of the Wisconsin Department of Health and Family Services. They offer monthly teleconferences. Previous teleconferences archived as pdf files of PowerPoint presentations by national experts. Succinct evidence-based overviews with clear practice recommendations. One of the best free-access websites in the country.

http://www.familypractice.com/lectures/drug/lecture_drug_text_frame.htm
Excellent on-line symposium by UW-Madison MDs and others, on chronic pain management, lack thereof, and discussions of opiate addiction. A real **must-see**, especially for WPP MDs, NPs, and RNs! The UW-Madison Medical School has been or is home to some of the national leaders in AODA research, (particularly brief interventions), and most notably Dr. Michael Fleming.

http://www.cme.wisc.edu/online/fas/index2.cfm University of Wisconsin Medical School, Madison Continuing Medical Education has online courses, some for free.

http://www.nattc.org/links.html National Addiction Technology Transfer Centers

http://www.samhsa.gov/centers/clearinghouse/clearinghouses.html
Has list of AODA screens and assessment instruments, with links to those available online.

HHS, NIH, National Institute of Mental Health (NIMH) www.nimh.nih.gov

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT) www.samhsa.gov
DHHS, SAMHSANational Clearinghouse for Alcohol and Drug Information (NCADI)
www.health.org, www.drugabuse.gov

HHS, NIH, National Institute on Alcohol Abuse and Alcoholism (NIAAA) www.niaaa.nih.gov

HHS, NIH, National Institute on Drug Abuse (NIDA) www.nida.nih.gov

HHS, NIH, National Institute on Drug Abuse's Club Drugs Web Site www.clubdrugs.org

HHS, NIH, National Library of Medicine (NLM) www.nlm.nih.govNational Library of Medicine Health Services/Technology Assessment Text (HSTAT) Web site.
National Clearinghouse for Alcohol and Drug Information (NCADI), NCADI's Web site
National Association of State Alcohol and Drug Abuse Directors www.nasadad.org
American Society of Addiction Medicine has numerous evidence-based practice guidelines for physicians. www.asam.org
Harvard Medical School Psychopharmacology Algorithm Project at : www.mhc.com/Algorithms

National Association on Alcohol, Drugs and Disability Inc. www.naadd.org
National Council for Community Behavioral Healthcare www.nccbh.org

National Council on Alcoholism and Drug Dependence (NCADD) www.ncadd.org

American Council on Alcoholism www.aca-usa.org
American Managed Behavioral www.ambha.org
American Medical Associationwww.ama-assn.org
American Psychiatric Association www.psych.org
American Psychological Association www.apa.org
International Nurses Society on Addictions www.intnsa.org
National **Association of Social Workers** www.socialworkers.org
National Association of Alcoholism and Drug Abuse Counselors www.naadac.org
National Committee for Quality Assurance www.ncqa.org
National Council for Community Behavioral Healthcare www.nccbh.org
National Health Law Program www.healthlaw.org
Physician Leadership on National Drug Policy PLNDP National Project Office, Center for Alcohol and Addiction Studies Brown University www.plndp.org

AOD Recovery Websites for Consumers, Families, and Professionals

A general web search yields thousands of sites related to alcoholism or addiction. Most of them are commercial, selling books, calendars, or in-patient treatment--complete with all those irritating pop-up ads. Below are the best sites we found. We left out most sites of individuals or treatment facilities, unless they had lots of good links.

www.alcoholscreening.org An on-line AUDIT questionnaire people can take. AlcoholScreening.org is a service of Join Together as part of its Demand Treatment! initiative. Join Together, a project of the Boston University School of Public Health, is supported by the Robert Wood Johnson Foundation.

http://www.nova.edu/~gsc/
This is an entry to a treatment clinic, but you can click on "on-line files" to access several good consumer guides, a few (unfortunately not all) in Spanish. The site focuses on individuals who are not severely dependent on alcohol and drugs and who want to take major responsibility for guiding their own change. The on-line files include information on normative alcohol consumption and health effects of alcohol and smoking, as well as brief-Intervention-type worksheets on deciding to cut down and strategies to do so. Their "Standard Drinks Card" shows the number of drinks per bottles of wine and liquor (which many others fail to show). The AUDIT questionnaire is there, as well as DAST10, a 10-question AODA screen. Smoking cessation and gambling programs are also available. The site sometimes "dead-ends" consumers by saying "Call us for professional treatment."
http://www.onlinerecovery.org/ Many links to special interest groups, meetings, etc.
http://www.recoverynetradio.com/ Talk radio, current events, etc. on AODA including tobacco.
http://www.giftofrecovery.com/ Full of sales and ads, but also on-line meetings, etc.
http://www.crackrecovery.com/ This is an individual's site but it has some good links.
http://www.recoverymd.com/Biology.htm. Uses 12-Step, disease model, but has good links described as technical or accessible.
http://www.recovery.org.uk/ U.K. website for information and advice about drug and alcohol abuse. "It's not just dry facts here. We describe the nature of addiction, the emotions involved - and

the plight of family members close to an addicted person. We emphasize that recovery is possible - both for the individual who has a chemical dependency - and for his or her family and friends."

http://recoverytools.org/ Great recovery site for people with mental illness
http://www.recoveryzone.org/ 12-Step
http://www.doctordeluca.com Here you'll find the big arguments over addiction vs. moderated or controlled drinking.

http://www.healthweb.org University of Minnesota Bio-Medical Library, University of Minnesota . Go to healthweb, then search on substance abuse to access a list of links and discussions.

12-Steps Sites

www.aa.org Alcoholics Anonymous
http://www.aarecovery.com/ Unofficial AA website
http://draonline.org/ Dual Recovery Anonymous--12-step recovery site for people with both AODA and mental illness. Thorough, with self-help worksheets.
http://www.essence-of-recovery.com/
http://www.hazelden.org/ Very full resource by one of nation's premier treatment facilities. This website has a wide variety of consumer self-help manuals on relapse prevention, a variety of dual diagnosis workbooks, women's issues, gay/lesbian issues, and many others. Many of these are very affordable and can be purchased for your consumers.
Recovery Networkwww.recoverynetwork.org
Sober24 (www.sober24.com) Interactive resources for managing one's recovery online.
http://www.recoverylane.com/ An individual's site (with irritating music) but has good links, although limited to 12-Step and Christian.
http://www.na.org/index.htm Narcotics Anonymous.
http://www.ca.org/index.html Cocaine Anonymous.
http://www.dualdiagnosis.org
This website sells a wide variety of self-help materials. There is also information on dual disorders, self-help information, treatment information, and a variety of other supports.

Alternatives to 12-Steps

http://www.charlottekasl.com/ Charlotte Davis Kasl is the author of Many Roads, One Journey: Moving Beyond the 12 Steps, and Women, Sex, and Addiction. Her books provide an excellent support for those who choose to recover in a personalized way and who do not embrace the traditional AA model of recovery.
http://home.earthlink.net/~bhilliard/index.html. An individual's site, but with good links about women, post-trauma stress disorder, and AODA.
http://www.addictionalternatives.com This is a good self-empowerment site with self-assessment tools, explanations of stages of change, explanations of various alternatives. Some links are highly commercialized with pop-up ads.
www.rational.org Rational Recovery is opposed to the spiritual and approach of AA and other support groups. Rational Recovery promotes a concept of immediate self-recovery from addiction through the learned skill of planned abstinence. The method used is called Addictive Voice Recognition Technique® (AVRT), which is basically constructing a life-and-death battle between one's healthy sober self and one's internal addict. Web site has some free info and discussion forums, but also sells an online course on AVRT, books, audiotapes, videotapes, articles and essays.

LifeRing Secular Recovery (www.unhooked.com) This non-religious recovery network is based on a group process self-help system of recovery. The web site provides a national meeting list organized by state, news bulletins, online scientific articles, a chat room with daily online meetings, reviews of recovery books, and extensive links organized by topic such as recovery groups, government/academic sites, and various approaches to healing.

SMART Recovery (Self Management and Recovery Training) (www.smartrecovery.org) This nationwide not-for-profit organization provides free self-help support groups to people who want to abstain from addictive behavior. The program is based on cognitive, behavioral and educational methods that seek to change the beliefs and attitudes that can lead to addictive behavior. There is no religious or spiritual component to this method of recovery. The site has online recovery meetings, a message board, Internet discussion groups, a meeting list and recommended reading.

http://www.secularsobriety.org "Save Our Selves" Non-religious alternative to AA.

National Latino Council on Alcohol and Tobacco Prevention www.nlcatp.org
Jewish Alcoholics, Chemically Dependent Persons and Significant Others www.jacsweb.org
National Asian Pacific American Families Against Substance Abuse, Inc. www.napafasa.org
National Association for Children of Alcoholics www.nacoa.org

http://www.multilingual-health-education.net

http://www.diversityrx.org/HTML/DIVRX.htm

http://ethnomed.org/ethnomed

Cravings Research

ALCOHOL ALERT

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Many researchers and clinicians consider craving an important contributor to the development and maintenance of alcoholism (1). Craving has been described as a powerful urge to drink or as intense thoughts about alcohol. The *International Classification of Diseases (ICD–10)* includes craving as an optional diagnostic criterion for addiction to alcohol or other drugs, defining the term as a strong desire or sense of compulsion to take the drug[1](2,3). Understanding the exact nature of craving has been difficult. Nevertheless, scientists have accumulated a large amount of data on its mechanisms and manifestations. This *Alcohol Alert* reviews how this information has stimulated the development of psychological and pharmacological approaches for maintaining abstinence among alcoholics during and after treatment.

[1]*The lack of consensus in this area is indicated by the omission of craving from the diagnostic criteria for alcoholism in the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV) (3).*

Models of Craving

Many theoretical models attempt to explain the phenomena associated with craving. Although no single model accounts for all aspects of craving, each has elements that may eventually contribute to an overall, comprehensive model. Key characteristics of selected models are described below.

- The reinforcement model is based on alcohol's ability to produce an elevated mood or to help relieve an unpleasant mental state such as stress or anger. An unconscious learning process called reinforcement leads to repetition of the behavior (i.e., drinking) that produces the positive experience (4). Eventually, objects, environments, or emotions consistently associated with alcohol consumption can produce a similar response as powerfully as can alcohol itself. Such stimuli (i.e., cues) may include the sight of a bar, liquor store, or beverage advertisement; the company of friends who drink; or exposure to alcohol itself. An abstinent alcoholic exposed to appropriate cues will experience a conscious urge, or craving, for alcohol (5).

- According to the social learning model, cue-elicited craving during or after treatment can trigger conscious coping strategies aimed at maintaining abstinence. The success of coping depends on the drinker's confidence in his or her ability to resist the urge to drink (6). This model acknowledges craving as only one of several factors necessary to induce

relapse (7).

- The cognitive processing model postulates that alcohol use becomes a habit which requires little conscious effort or attention, just as driving down a familiar road can become automatic. In this model, craving represents the effort involved in mobilizing conscious problem-solving skills needed to block the automatic drinking behavior. Such a situation may occur when a drinker finds that his favorite bar is unexpectedly closed. Similarly, following treatment, an alcoholic who is motivated to remain abstinent might experience craving while consciously attempting to avoid cue-induced relapse (7,8).

Measuring Craving

Reliable methods for measuring craving are required to support meaningful experimental results or clinical evaluations. Many studies simply ask the subject to rate the intensity of his or her desire to drink, sometimes in the presence of an alcohol-related cue (9). To add objective measures to this method (10), researchers began recording changes in specific physiological functions thought to accompany craving (e.g., changes in heart rate, blood pressure, or sweat gland activity) (11). Because physiological changes such as these are not specific to craving, they have not correlated consistently with self-reported urges to drink (7). In addition, some tests rely on the self-rating of only one selected item out of the many aspects of craving, thereby providing an incomplete basis for comparison (11).

Researchers have developed multi-item scales to make self-report instruments more precise. The scale items on such tests not only cover multiple aspects of craving, but often overlap by asking essentially the same question different ways. This technique helps counter errors introduced by differences in the way individuals interpret subjective questions (12). One of the best known multi-item scales is based on the observation that at least some aspects of craving appear to resemble features of obsessive-compulsive disorder (OCD), a condition characterized by repetitive or obsessive thoughts and impulsive or compulsive repetitive behaviors (13). The Obsessive Compulsive Drinking Scale (OCDS) was developed from existing questionnaires for assessing nonalcohol-related OCD. A key item measured by the OCDS is a person's ability to resist or suppress urges to drink. The strength of this ability may be crucial for initial treatment success and the subsequent maintenance of abstinence. Preliminary experimental data suggest that the OCDS can help to assess the severity of alcoholism (14,15), monitor the progress of patients in treatment, and assess treatment outcomes (13,14,16).

Craving and the Brain

To understand craving, scientists must identify the brain mechanisms that lead to urges. This information is necessary to support the development of new and improved alcoholism treatment approaches. To account for all manifestations of craving, both conscious and unconscious processes must be taken into account (13).

Alcohol consumption may initiate the process of reinforcement by activating a "reward center" located deep within the brain. The reward center is linked to other brain areas involved in aspects of emotion, learning, and memory. Interactions among these sites could account for the processes by which (1) emotion-laden memories of past positive drinking experiences become associated with cues, and (2) exposure to such cues can activate the reward center in the absence of alcohol, potentially leading to craving during abstinence. These processes are unconscious. However, the reward center also communicates with brain areas that appear to underlie higher intellectual (i.e.,

cognitive) functions such as judgment and decisionmaking. Because of this, heavy drinking may ultimately impair conscious processes that support the ability to cope with drinking urges (6).

A contrary view suggests that exposure to cues may lead to the *activation* of certain "automatic" cognitive functions, resulting in repetitive, unwanted thoughts about alcohol. These automatic thoughts are the cognitive equivalent of unconscious craving (13).

Craving also may arise in part from persistent nervous system changes (i.e., neuroadaptation) that leave the alcoholic's brain vulnerable to relapse drinking (17). These changes persist in the absence of alcohol, and may result in conscious or unconscious physical and mental distress. This phenomenon could account for the craving alcoholics experience soon after the cessation of drinking, and which makes them vulnerable to relapse for a protracted period of time.

A comprehensive picture of craving requires the integration of unconscious and cognitive mechanisms (7). Among the concepts of craving discussed here, both the social learning and cognitive processing models implicate cognitive learning in the development of harmful drinking patterns and stress the importance of teaching conscious coping strategies in alcoholism therapy. Both of these models also are consistent with the involvement of other causal mechanisms, including reinforcement and other unconscious processes (6,8).

Imaging Studies. Few craving studies have been conducted using imaging techniques, which allow scientists to locate areas of brain cell activity in living subjects with minimal risk. Some craving studies based on imaging of humans have identified specific regional changes in brain cell activity in response to alcohol-related cues (18–20). However, these findings alone do not prove that the observed brain changes cause the subjective sensation of craving (9). Additional research is needed to understand the neurobiology of craving.

Treatment

Despite the difficulties involved in the study of craving, research results have contributed significantly to our knowledge base for developing and validating alcoholism therapies for achieving and maintaining abstinence.

Psychological Therapy. Treatment programs often use relapse prevention approaches that incorporate some of the principles of cognitive-behavioral therapy. In alcoholism treatment, this approach helps the patient recognize the cues that lead to drinking so as to be better prepared to deal with them when encountered. Patients develop the skills and self-confidence to cope with high-risk situations such as negative emotional states (e.g., anger or depression), interpersonal conflict, and social pressure to drink (7,21). The informal use of similar coping strategies may contribute to the success of 12-step self-help programs (22).

Pharmacotherapy. The results of craving research have spurred the development of new medications to supplement verbal alcoholism therapies. Among the most promising of such medications are naltrexone (ReVia™) and acamprosate.

Naltrexone is the only commercially available medication in the United States that targets alcohol's effects on the brain. When combined with various treatment programs, naltrexone has been found to decrease drinking rates, prolong abstinence, and hinder relapse to uncontrolled drinking among abstinent alcoholics who sampled alcohol during treatment (23,24,15,16,25,26). Sinclair suggests that naltrexone could be administered to actively drinking alcoholics during treatment and subsequently on an as-needed basis only when drinking is anticipated (i.e., targeted treatment) (27). Some data to support this idea recently have been produced (28). Targeted use of naltrexone also may be effective for decreasing alcohol consumption levels among nonalcoholic problem drinkers (29).

Evidence suggests that acamprosate may diminish craving by helping to restore the physiological balance of the brain after abstinence has been achieved (26). Acamprosate improved various measures of abstinence in 14 of 16 European studies (26,30) and in a 21-site multicenter trial in the United States (31,32). Acamprosate is available by prescription in Europe and is awaiting approval by the U.S. Food and Drug Administration for use in this country.

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Alcohol and Sleep

National Institute on Alcohol Abuse and Alcoholism

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The average adult sleeps 7.5 to 8 hours every night. Although the function of sleep is unknown, abundant evidence demonstrates that lack of sleep can have serious consequences, including increased risk of depressive disorders, impaired breathing, and heart disease. In addition, excessive daytime sleepiness resulting from sleep disturbance is associated with memory deficits, impaired social and occupational function, and car crashes (1,2). Alcohol consumption can induce sleep disorders by disrupting the sequence and duration of sleep states and by altering total sleep time as well as the time required to fall asleep (i.e., sleep latency). This *Alcohol Alert* explores the effects of alcohol consumption on sleep patterns, the potential health consequences of alcohol consumption combined with disturbed sleep, and the risk for relapse in those with alcoholism who fail to recover normal sleep patterns.

Sleep Structure, Onset, and Arousal

Before discussing alcohol's effects on sleep, it is helpful to summarize some basic features of normal sleep. A person goes through two alternating states of sleep, characterized in part by different types of brain electrical activity (i.e., brain waves). These states are called slow wave sleep (SWS), because in this type of sleep the brain waves are very slow, and rapid eye movement (REM) sleep, in which the eyes undergo rapid movements although the person remains asleep.

Most sleep is the deep, restful SWS. REM sleep occurs periodically, occupying about 25 percent of sleep time in the young adult. Episodes of REM normally recur about every 90 minutes and last 5 to 30 minutes. REM sleep is less restful than SWS and is usually associated with dreaming. Although its function is unknown, REM appears to be essential to health. In rats, deprivation of REM sleep can lead to death within a few weeks (3). In addition, a transitional stage of light sleep occurs at intervals throughout the sleep period (4).

Sleep was formerly attributed to decreased activity of brain systems that maintain wakefulness. More recent data indicate that sleep, like consciousness, is an active process. Sleep is controlled largely by nerve centers in the lower brain stem, where the base of the brain joins the spinal cord. Some of these nerve cells produce serotonin, a chemical messenger associated with sleep onset (5) and with the regulation of SWS. Certain other nerve cells produce norepinephrine, which helps regulate REM sleep and facilitates arousal (6). The exact roles and interactions of these and other chemical messengers in orchestrating sleep patterns are not known (6). Significantly, however, alcohol consumption affects the function of these and other chemical messengers that appear to influence sleep.

Alcohol and Sleep in Those Without Alcoholism

Alcohol consumed at bedtime, after an initial stimulating effect, may decrease the time required to fall asleep. Because of alcohol's sedating effect, many people with insomnia consume alcohol to promote sleep. However, alcohol consumed within an hour of bedtime appears to disrupt the second half of the sleep period (7). The subject may sleep fitfully during the second half of sleep, awakening from dreams and returning to sleep with difficulty. With continued consumption just before bedtime, alcohol's sleep-inducing effect may decrease, while its disruptive effects continue or increase (8). This sleep disruption may lead to daytime fatigue and sleepiness. The elderly are at particular risk, because they achieve higher levels of alcohol in the blood and brain than do younger persons after consuming an equivalent dose. Bedtime alcohol consumption among older persons may lead to unsteadiness if walking is attempted during the night, with increased risk of falls and injuries (3).

Alcoholic beverages are often consumed in the late afternoon (e.g., at "happy hour" or with dinner) without further consumption before bedtime. Studies show that a moderate dose[1] of alcohol consumed as much as 6 hours before bedtime can increase wakefulness during the second half of sleep. By the time this effect occurs, the dose of alcohol consumed earlier has already been eliminated from the body, suggesting a relatively long-lasting change in the body's mechanisms of sleep regulation (7,8).

The adverse effects of sleep deprivation are increased following alcohol consumption. Subjects administered low doses of alcohol following a night of reduced sleep perform poorly in a driving simulator, even with no alcohol left in the body (9,10). Reduced alertness may potentially increase alcohol's sedating effect in situations such as rotating sleep-wake schedules (e.g., shift work) and rapid travel across multiple time zones (i.e., jet lag) (9). A person may not recognize the extent of sleep disturbance that occurs under these circumstances, increasing the danger that sleepiness and alcohol consumption will co-occur.

Alcohol and Breathing Disorders

Approximately 2 to 4 percent of Americans suffer from obstructive sleep apnea (OSA), a disorder in which the upper air passage (i.e., the pharynx, located at the back of the mouth) narrows or closes during sleep (11). The resulting episode of interrupted breathing (i.e., apnea) wakens the person, who then resumes breathing and returns to sleep. Recurring episodes of apnea followed by arousal can occur hundreds of times each night, significantly reducing sleep time and resulting in daytime sleepiness. Those with alcoholism appear to be at increased risk for sleep apnea, especially if they snore (12). In addition, moderate to high doses of alcohol consumed in the evening can lead to narrowing of the air passage (13,14), causing episodes of apnea even in persons who do not otherwise exhibit symptoms of OSA. Alcohol's general depressant effects can increase the duration of periods of apnea, worsening any preexisting OSA (14).

OSA is associated with impaired performance on a driving simulator as well as with an increased rate of motor vehicle crashes in the absence of alcohol consumption (9,10). Among patients with severe OSA, alcohol consumption at a rate of two or more drinks per day is associated with a fivefold increased risk for fatigue-related traffic crashes compared with OSA patients who consume little or no alcohol (15). In addition, the combination of alcohol, OSA, and snoring increases a person's risk for heart attack, arrhythmia, stroke, and sudden death (16).

Age-Related Effects and the Impact of Drinking

Little research has been conducted on the specific effects of alcohol on sleep states among different age groups. Scher (17) investigated the effects of prenatal alcohol exposure on sleep patterns in infants. Measurements of brain electrical activity demonstrated that infants of mothers who consumed at least one drink per day during the first trimester of pregnancy exhibited sleep disruptions and increased arousal compared with infants of nondrinking women. Additional studies revealed that infants exposed to alcohol in mothers' milk fell asleep sooner but slept less overall than those who were not exposed to alcohol (18). The exact significance of these findings is unclear.

Normal aging is accompanied by a gradual decrease in SWS and an increase in nighttime wakefulness. People over 65 often awaken 20 times or more during the night, leading to sleep that is less restful and restorative (3). Age-related sleep deficiencies may encourage the use of alcohol to promote sleep, while increasing an older person's susceptibility to alcohol-related sleep disturbances (3,19). Potential sources of inconsistency among study results include different doses of alcohol employed and failure to screen out subjects with preexisting sleep disorders (3).

Effects of Alcohol on Sleep in Those With Alcoholism

Active Drinking and Withdrawal. Sleep disturbances associated with alcoholism include increased time required to fall asleep, frequent awakenings, and a decrease in subjective sleep quality associated with daytime fatigue (3). Abrupt reduction of heavy drinking can trigger alcohol withdrawal syndrome, accompanied by pronounced insomnia with marked sleep fragmentation. Decreased SWS during withdrawal may reduce the amount of restful sleep. It has been suggested that increased REM may be related to the hallucinations that sometimes occur during withdrawal. In patients with severe withdrawal, sleep may consist almost entirely of brief periods of REM interrupted by numerous awakenings (3,20).

Recovery and Relapse. Despite some improvement after withdrawal subsides, sleep patterns may never return to normal in those with alcoholism, even after years of abstinence (3,21). Abstinent alcoholics tend to sleep poorly, with decreased amounts of SWS and increased nighttime wakefulness that could make sleep less restorative and contribute to daytime fatigue (22). Resumption of heavy drinking leads to increased SWS and decreased wakefulness. This apparent improvement in sleep continuity may promote relapse by contributing to the mistaken impression that alcohol consumption improves sleep (23-25). Nevertheless, as drinking continues, sleep patterns again become disrupted (3).

Researchers have attempted to predict relapse potential using measures of sleep disruption. Gillin and colleagues (26) measured REM sleep in patients admitted to a 1-month alcoholism treatment program. Higher levels of REM predicted those who relapsed within 3 months after hospital discharge in 80 percent of the patients. A review of additional research (3) concluded that those who eventually relapsed exhibited a higher proportion of REM and a lower proportion of SWS at the beginning of treatment, compared with those who remained abstinent. Although additional research is needed, these findings may facilitate early identification of patients at risk for relapse and allow clinicians to tailor their treatment programs accordingly.

Alcohol and Sleep--A Commentary by NIAAA Director Enoch Gordis, M.D.

According to recent news reports, Americans are at risk for a variety of sleep-related health problems. Alcohol use affects sleep in a number of ways and can exacerbate these problems. Because alcohol use is widespread, it is important to understand how this use affects sleep to increase risk for illness. For example, it is popularly believed that a drink before bedtime can aid falling asleep. However, it also can disrupt normal sleep patterns, resulting in increased fatigue and physical stress to the body. Alcohol use can aggravate sleeping disorders, such as sleep apnea; those with such disorders should be cautious about alcohol use. Many nursing mothers are still regularly advised by their physicians to have a drink to promote lactation (so-called let-down reflex). Babies who receive alcohol in breast milk are known to have disrupted sleeping patterns. Because researchers do not yet know what effect this disruption has on nursing infants, physicians should reconsider this advice. Alcoholism treatment also can be complicated by sleep problems during withdrawal and during subsequent behavioral treatment, where sleeping problems experienced by many recovering alcoholics may increase their risk for relapse. Because it is likely that alcohol may act on the same neurotransmitters involved in sleep, increased knowledge of alcohol's effects on the brain will help to promote new therapeutic techniques for alcohol-related sleep disorders and, perhaps, improve the chance for long-term sobriety.

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[1]A standard drink is generally considered to be 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of distilled spirits, each drink containing approximately 0.5 ounce of alcohol. In addition, terms such as light, moderate, or heavy drinking are not used consistently by alcoholism researchers. Therefore, in each case, the terms used in this text are those of the author or authors cited.

Alcohol and Nutrition

National Institute on Alcohol Abuse and Alcoholism October 1993, Updated October 2000

Nutrition is a process that serves two purposes: to provide energy and to maintain body structure and function. Food supplies energy and provides the building blocks needed to replace worn or damaged cells and the nutritional components needed for body function. Alcoholics often eat poorly, limiting their supply of essential nutrients and affecting both energy supply and structure maintenance. Furthermore, alcohol interferes with the nutritional process by affecting digestion, storage, utilization, and excretion of nutrients (1).

Impairment of Nutrient Digestion and Utilization

Once ingested, food must be digested (broken down into small components) so it is available for energy and maintenance of body structure and function. Digestion begins in the mouth and continues in the stomach and intestines, with help from the pancreas. The nutrients from digested food are absorbed from the intestines into the blood and carried to the liver. The liver prepares nutrients either for immediate use or for storage and future use. Alcohol inhibits the breakdown of nutrients into usable molecules by decreasing secretion of digestive enzymes from the pancreas (2). Alcohol impairs nutrient absorption by damaging the cells lining the stomach and intestines and disabling transport of some nutrients into the blood (3). In addition, nutritional deficiencies themselves may lead to further absorption problems. For example, folate deficiency alters the cells lining the small intestine, which in turn impairs absorption of water and nutrients including glucose, sodium, and additional folate (3). Even if nutrients are digested and absorbed, alcohol can prevent them from being fully utilized by altering their transport, storage, and excretion (4). Decreased liver stores of vitamins such as vitamin A (5), and increased excretion of nutrients such as fat, indicate impaired utilization of nutrients by alcoholics (3).

Alcohol and Energy Supply

The three basic nutritional components found in food--carbohydrates, proteins, and fats--are used as energy after being converted to simpler products. Some alcoholics ingest as much as 50 percent of their total daily calories from alcohol, often neglecting important foods (3,6). Even when food intake is adequate, alcohol can impair the mechanisms by which the body controls blood glucose levels, resulting in either increased or decreased blood glucose (glucose is the body's principal sugar) (7). In nondiabetic alcoholics, increased blood sugar, or hyperglycemia--caused by impaired insulin secretion--is usually temporary and without consequence. Decreased blood sugar, or hypoglycemia, can cause serious injury even if this condition is short lived. Hypoglycemia can occur when a fasting or malnourished person consumes alcohol. When there is no food to supply energy, stored sugar is depleted, and the products of alcohol metabolism inhibit the formation of glucose from other compounds such as amino acids (7). As a result, alcohol causes the brain and other body tissue to be deprived of glucose needed for energy and function.

Although alcohol is an energy source, how the body processes and uses the energy from alcohol is more complex than can be explained by a simple calorie conversion value (8). For example, alcohol provides an average of 20 percent of the calories in the diet of the upper third of drinking Americans, and we might expect many drinkers who consume such amounts to be obese. Instead,

national data indicate that, despite higher caloric intake, drinkers are no more obese than nondrinkers (9,10). Also, when alcohol is substituted for carbohydrates, calorie for calorie, subjects tend to lose weight, indicating that they derive less energy from alcohol than from food (summarized in 8). The mechanisms accounting for the apparent inefficiency in converting alcohol to energy are complex and incompletely understood (11), but several mechanisms have been proposed. For example, chronic drinking triggers an inefficient system of alcohol metabolism, the microsomal ethanol-oxidizing system (MEOS) (1). Much of the energy from MEOS-driven alcohol metabolism is lost as heat rather than used to supply the body with energy.

Alcohol and the Maintenance of Cell Structure and Function & Structure

Because cells are made mostly of protein, an adequate protein diet is important for maintaining cell structure, especially if cells are being damaged. Research indicates that alcohol affects protein nutrition by causing impaired digestion of proteins to amino acids, impaired processing of amino acids by the small intestine and liver, impaired synthesis of proteins from amino acids, and impaired protein secretion by the liver (3). Nutrients are essential for proper body function; proteins, vitamins, and minerals provide the tools that the body needs to perform properly. Alcohol can disrupt body function by causing nutrient deficiencies and by usurping the machinery needed to metabolize nutrients.

Vitamins. Vitamins are essential to maintaining growth and normal metabolism because they regulate many physiological processes. Chronic heavy drinking is associated with deficiencies in many vitamins because of decreased food ingestion and, in some cases, impaired absorption, metabolism, and utilization (1,12). For example, alcohol inhibits fat absorption and thereby impairs absorption of the vitamins A, E, and D that are normally absorbed along with dietary fats (12,13). Vitamin A deficiency can be associated with night blindness, and vitamin D deficiency is associated with softening of the bones (6). Vitamins A, C, D, E, K, and the B vitamins, also deficient in some alcoholics, are all involved in wound healing and cell maintenance (14). In particular, because vitamin K is necessary for blood clotting, deficiencies of that vitamin can cause delayed clotting and result in excess bleeding. Deficiencies of other vitamins involved in brain function can cause severe neurological damage.

Minerals. Deficiencies of minerals such as calcium, magnesium, iron, and zinc are common in alcoholics, although alcohol itself does not seem to affect the absorption of these minerals (15). Rather, deficiencies seem to occur secondary to other alcohol-related problems: decreased calcium absorption due to fat malabsorption; magnesium deficiency due to decreased intake, increased urinary excretion, vomiting, and diarrhea (16); iron deficiency related to gastrointestinal bleeding (3,15); and zinc malabsorption or losses related to other nutrient deficiencies (17). Mineral deficiencies can cause a variety of medical consequences from calcium-related bone disease to zinc-related night blindness and skin lesions.

Alcohol, Malnutrition, and Medical Complications

Liver Disease : Although alcoholic liver damage is caused primarily by alcohol itself, poor nutrition may increase the risk of alcohol-related liver damage. For example, nutrients normally found in the liver, such as carotenoids, which are the major sources of vitamin A, and vitamin E compounds, are known to be affected by alcohol consumption (18,19). Decreases in such nutrients may play some role in alcohol-related liver damage.

Pancreatitis: Research suggests that malnutrition may increase the risk of developing alcoholic pancreatitis (20,21), but some research performed outside the United States links pancreatitis more closely with overeating (21). Preliminary research suggests that alcohol's damaging effect on the pancreas may be exacerbated by a protein-deficient diet (22).

Brain: Nutritional deficiencies can have severe and permanent effects on brain function. Specifically, thiamine deficiencies, often seen in alcoholics, can cause severe neurological problems such as impaired movement and memory loss seen in Wernicke/Korsakoff syndrome (23).
Pregnancy :Alcohol has direct toxic effects on fetal development, causing alcohol-related birth defects, including fetal alcohol syndrome. Alcohol itself is toxic to the fetus, but accompanying nutritional deficiency can affect fetal development, perhaps compounding the risk of developmental damage (24,25). The nutritional needs during pregnancy are 10 to 30 percent greater than normal; food intake can increase by as much as 140 percent to cover the needs of both mother and fetus (24). Not only can nutritional deficiencies of an alcoholic mother adversely affect the nutrition of the fetus, but alcohol itself can also restrict nutrition flow to the fetus (24,25).
Nutritional Status of Alcoholics: Techniques for assessing nutritional status include taking body measurements such as weight, height, mass, and skin fold thickness to estimate fat reserves, and performing blood analysis to provide measurements of circulating proteins, vitamins, and minerals. These techniques tend to be imprecise, and for many nutrients, there is no clear "cut-off" point that would allow an accurate definition of deficiency (4). As such, assessing the nutritional status of alcoholics is hindered by the limitations of the techniques. Dietary status may provide inferential information about the risk of developing nutritional deficiencies. Dietary status is assessed by taking patients' dietary histories and evaluating the amount and types of food they are eating. A threshold dose above which alcohol begins to have detrimental effects on nutrition is difficult to determine. In general, moderate drinkers (two drinks or less per day) seem to be at little risk for nutritional deficiencies. Various medical disorders begin to appear at greater levels. Research indicates that the majority of even the heaviest drinkers have few detectable nutritional deficiencies but that many alcoholics who are hospitalized for medical complications of alcoholism do experience severe malnutrition (1,12). Because alcoholics tend to eat poorly--often eating less than the amounts of food necessary to provide sufficient carbohydrates, protein, fat, vitamins A and C, the B vitamins, and minerals such as calcium and iron (6,9,26)--a major concern is that alcohol's effects on the digestion of food and utilization of nutrients may shift a mildly malnourished person toward severe malnutrition.

Alcohol and Nutrition--A Commentary by NIAAA Director Enoch Gordis, M.D.
The combination of an adequate diet and abstention from alcohol is the best way to treat malnourished alcoholic patients. Nutritional supplements have been used to replace nutrients deficient in malnourished alcoholics in an attempt to improve their overall health. Dosages of nutritional supplements such as vitamin A that exceed normally prescribed levels may result in overdose. Although various nutritional approaches have been touted as "cures" for alcoholism, there is little evidence to support such claims. However, renewed research attention to the nutritional aspects of alcohol leaves open the possibility that a role for nutritional therapy in alcoholism treatment may yet be defined.
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Public Health Service * National Institutes of Health

Updated: October 2000

Alcoholism Treatment Overview

ALCOHOL ALERT

National Institute on Alcohol Abuse and Alcoholism No. 49 October 2000

New Advances in Alcoholism Treatment

More than 700,000 Americans receive alcoholism treatment on any given day (1). However, the techniques of alcoholism therapy have traditionally been based on clinical experience and intuition, with little rigorous validation of their effectiveness (2). Over the past 20 years, modern methods of evaluating medical therapies have been increasingly applied to alcoholism treatment. These methods include the use of control groups for comparison purposes, random assignment of study participants to different treatment groups and, to the greatest extent possible, followup of all patients who entered the study (3). This issue focuses on the results of recent controlled clinical studies on the effectiveness of self-help groups, psychosocial approaches, and medications in achieving and maintaining abstinence.

Twelve-Step Self-Help Programs

Self-help groups are the most commonly sought source of help for alcohol-related problems (4). Alcoholics Anonymous (AA), one of the most commonly known self-help groups, outlines 12 consecutive activities, or steps, that alcoholics should achieve during the recovery process. Alcoholics can become involved with AA before entering professional treatment, as a part of it, or as aftercare following professional treatment. Although AA appears to produce positive outcomes in many of its members (5,6), its efficacy has rarely been assessed in randomized clinical trials (7).

One randomized study of patients entering employee assistance programs compared inpatient treatment combined with AA with referral to AA alone (8). This study found that inpatient treatment, a combination of professional treatment and AA, will achieve better results for more people than AA alone (8). Ouimette and colleagues (9), as part of a nonrandomized observational study involving 3,000 patients in Department of Veterans Affairs hospitals, compared predominantly 12-step programs with predominantly cognitive-behavioral programs as well as with courses of therapy that combined both approaches. In cognitive-behavioral therapy (CBT), the therapist helps the client learn new skills to cope with problems and to change harmful behavior patterns, such as alcohol abuse. One year after completion of treatment, the three types of programs had produced comparable improvements on measures of alcohol consumption and related problems. However, participants in the 12-step programs achieved more sustained abstinence and higher rates of employment compared with participants in the other two programs (9). Interpretation of these results is complicated by the nonrandom assignment of patients to the different treatment types (9).

The beneficial effects of AA may be attributable in part to the replacement of the participant's social network of drinking friends with a fellowship of AA members who can provide motivation and support for maintaining abstinence (4,10). In addition, AA's approach often results in the development of coping skills, many of which are similar to those taught in more structured psychosocial treatment settings, thereby leading to reductions in alcohol consumption (4,11).

Psychosocial Therapy

The following sections deal with selected recent approaches or considerations relevant to the psychosocial treatment of alcohol-related problems.

Motivational Enhancement Therapy

Developed specifically for Project MATCH,[1] motivational enhancement therapy (MET) begins with the assumption that the responsibility and capacity for change lie within the client (12,13). The therapist begins by providing individualized feedback about the effects of the patient's drinking. Working closely together,

therapist and patient explore the benefits of abstinence, review treatment options, and design a plan to implement treatment goals. Analysis suggests that MET may be one of the most cost-effective of available treatment methods (14). In one study (15), the motivational interviewing technique—a key component of MET—was shown to overcome patients' reluctance to enter treatment more effectively than did conventional techniques.

Couples Therapy

Evidence indicates that involvement of a nonalcoholic spouse in a treatment program can improve patient participation rates and increase the likelihood that the patient will alter drinking behavior after treatment ends (16).

There are various approaches to marital family therapy. Behavioral-marital therapy (BMT) combines a focus on drinking with efforts to strengthen the marital relationship through shared activities and the teaching of communication and conflict evaluation skills (17). O'Farrell and colleagues (18) combined couples therapy with the learning and rehearsal of a relapse prevention plan. Among alcoholics with severe marital and drinking problems, the combination approach produced improved marital relations and higher abstinence rates through 30 months of followup compared with patients undergoing only BMT (18,19).

Brief Interventions

Many persons with alcohol-related problems receive counseling from primary care physicians or nursing staff in the context of five or fewer standard office visits (20). Such treatment, known as brief intervention, generally consists of straightforward information on the negative consequences of alcohol consumption along with practical advice on strategies and community resources to achieve moderation or abstinence (21,22). Two controlled trials in the United States and Canada demonstrated that this approach reduced drinking (23,24), alcohol-related problems (24), and patients' use of health care services (23). Most brief interventions are designed to help those at risk for developing alcohol-related problems to reduce their alcohol consumption. Alcohol-dependent patients are encouraged to enter specialized treatment with the goal of complete abstinence (21).

The brief intervention approach has also been successfully applied outside the primary care setting. Evidence suggests that 25 to 40 percent of trauma patients may be alcohol dependent (25). Gentilello and colleagues (26) conducted a randomized controlled study among patients in a trauma center who had detectable blood alcohol levels at the time of admission. The researchers found that a single motivational interview at or near the time of discharge reduced drinking levels and re-admission for trauma during 6 months of followup (26). Monti and colleagues (27) conducted a similar randomized controlled study among youth ages 18 to 19 admitted to an emergency room with alcohol-related injuries. After 6 months, although all participants had decreased their alcohol consumption, the group receiving brief intervention had a significantly lower incidence of drinking and driving, traffic violations, alcohol-related injuries, and alcohol-related problems (27).

Brief intervention among freshman college students previously identified as being at high risk for harmful consequences of heavy drinking has been shown to result in a significant decline in alcohol-related problems (28,29).

Treating Alcohol and Nicotine Addiction Together

Nicotine and alcohol interact in the brain, each drug possibly affecting vulnerability to dependence on the other (30). Consequently, some researchers postulate that treating both addictions simultaneously might be an effective, even essential, way to help reduce dependence on both. A recent study by Hurt and colleagues (31) showed that treatment for nicotine dependence did not interfere with abstinence from alcohol or other drugs. Furthermore, such concurrent treatment not only enhanced cessation from smoking, it also did not induce already abstinent smokers to relapse to drinking.

Pharmacotherapy

More recently, research has focused on the development of medications for blocking alcohol-brain interactions that might promote alcoholism. In 1995 the U.S. Food and Drug Administration approved the use of the medication naltrexone (ReVia™) as an aid in preventing relapse among recovering alcoholics who are simultaneously undergoing psychosocial therapy. This approval was based largely on two randomized controlled studies that showed decreased alcohol consumption for longer periods in naltrexone-treated patients compared with those who received a placebo (32,33).

As is the case with all diseases, however, naltrexone is only effective if taken on a regular basis (34). Like all medications, naltrexone has side effects. One recent study reported a high rate of side effects, which

probably explains why this study, in contrast with most other studies, failed to find naltrexone effective (35). Acamprosate showed promise in treating alcoholism in several randomized controlled European trials involving more than 3,000 alcoholic subjects who were also undergoing psychosocial treatment. Analysis of combined results showed that more than twice as many alcoholics receiving acamprosate remained abstinent up to 1 year compared with subjects receiving psychosocial treatment alone (36).

Research suggests that some medications may be more effective for certain types of alcoholics. For example, when ondansetron (Zofran®) was combined with psychotherapy, alcoholics who had begun drinking heavily before age 25 (i.e., early-onset alcoholics) decreased their alcohol consumption and increased their number of abstinent days, but later onset alcoholics did not (37). Sertraline (Zoloft®), in contrast, appears to reduce drinking in late-onset, but not early-onset, alcoholics (38). However, fluoxetine (Prozac®), a medication related to sertraline, has not been found to be effective in late-onset alcoholism (39).

In conclusion, research supports the concept of using medications as an adjunct to the psychosocial therapy of alcohol abuse and alcoholism. However, additional clinical trials are required to identify those patients most likely to benefit from such an approach, to determine the most appropriate medications for different patient types, to establish optimal dosages, and to develop strategies for enhancing patient compliance with medication regimens.

New Advances in Alcoholism Treatment—A Commentary by NIAAA Director Enoch Gordis, M.D.

Alcoholism clinicians have access today to a wide range of treatment options for their patients. Some of these treatments, such as 12-step self-help programs, have been around a long time. Others—including brief intervention and various therapies borrowed from other fields, such as motivational enhancement therapy and couples therapy—are relatively new concepts that have been shown to be effective in reducing the risk for alcohol-related problems. The key change that has occurred, of course, is the advent of alcoholism clinical research, which over the past 15 years or so has made significant progress toward rigorous evaluation of both existing therapies and newly developed therapies for use in treating alcohol-related problems. Finally, continued research on alcohol's effects in the brain and on the links between brain and behavior, which has already led to the development of medications to reduce craving, is likely to provide clinicians with a range of highly specific medications that will, when used in conjunction with behavioral therapies, improve the chance for recovery—and the lives—of those who suffer from alcohol abuse and dependence.

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[1]Project MATCH is a national, multisite, randomized clinical trial that produced data on the outcomes of specific alcoholism treatment approaches.

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Copies of the *Alcohol Alert* are available free of charge from the National Institute on Alcohol Abuse and Alcoholism Publications Distribution Center, P.O. Box 10686, Rockville, MD 20849-0686.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service * National Institutes of Health

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Substance Abuse Among Older Adults

Brief Summary

TITLE:
Substance abuse among older adults.

SOURCE(S):
Substance Abuse and Mental Health Services Administration (SAMHSA). Substance abuse among older adults. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1998. 173 p. (Treatment improvement protocol (TIP) series; no. 26). [396 references]

ADAPTATION:
Not applicable: Guideline was not adapted from another source.

RELEASE DATE:
1998

MAJOR RECOMMENDATIONS:
The Treatment Improvement Protocol's (TIP) recommendations appear below in italic type. Those based on research evidence are marked (1), whereas those based on Panel members' clinical experience are marked (2).

Alcohol Abuse

Physiological changes, as well as changes in the kinds of responsibilities and activities pursued by older adults, make established criteria for classifying alcohol problems often inadequate for this population.

One widely used model for understanding alcohol problems is the medical diagnostic model as defined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*). The DSM-IV criteria for substance dependence include some that do not apply to many older adults and may lead to under-identification of drinking problems.

Diagnostic criteria for alcohol dependence are subsumed within the DSM-IV's general criteria for substance dependence. Dependence is defined as a "maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period" .

The Panel recommends that clinicians consider that the DSM-IV criteria for substance abuse and dependence may not be adequate to diagnose older adults with alcohol problems. **(2)**

Figure 2-3, taken from the original guideline document provides an outline of special considerations.

Figure 2-3 **Applying DSM-IV Diagnostic Criteria to Older Adults With Alcohol Problems**
Diagnostic criteria for alcohol dependence are subsumed within the DSM-IV's general criteria for substance dependence. Dependence is defined as a "maladaptive pattern of substance use, leading to

clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period" (American Psychiatric Association, 1994, p. 181). There are special considerations when applying DSM-IV criteria to older adults with alcohol problems.

Criteria	Special Considerations for Older Adults
1. Tolerance	May have problems with even low intake due to increased sensitivity to alcohol and higher blood alcohol levels
2. Withdrawal	Many late onset alcoholics do not develop physiological dependence
3. Taking larger amounts or over a longer period than was intended	Increased cognitive impairment can interfere with self-monitoring; drinking can exacerbate cognitive impairment and monitoring
4. Unsuccessful efforts to cut down or control use	Same issues across life span
5. Spending much time to obtain and use alcohol and to recover from effects	Negative effects can occur with relatively low use
6. Giving up activities due to use	May have fewer activities, making detection of problems more difficult
7. Continuing use despite physical or psychological problem caused by use	May not know or understand that problems are related to use, even after medical advice

Some experts use the model of at-risk, heavy, and problem drinking in place of *the DSM-IV* model of alcohol abuse and dependence because it allows for more flexibility in characterizing drinking patterns. In this classification scheme, an *at-risk drinker* is one whose patterns of alcohol use, although not yet causing problems, may bring about adverse consequences, either to the drinker or to others. As their names imply, the terms *heavy* and *problem* drinking signify more hazardous levels of consumption. Although the distinction between the terms *heavy* and *problem* is meaningful to alcohol treatment specialists interested in differentiating severity of problems among younger alcohol abusers, it is less relevant to older adults. *To differentiate older drinkers, the Panel recommends using the terms at-risk and problem drinkers only.* **(2)** In the two-stage conceptualization recommended by the Panel, the *problem drinker* category includes those who would otherwise fall into the *heavy* and *problem* classifications in the more traditional model as well as those who meet the DSM-IV criteria for abuse and dependence.

The Consensus Panel recommends that older men consume

- *No more than one drink per day* **(1)**
- *A maximum of two drinks on any drinking occasion (e.g., New Year's Eve, weddings).* **(1)**

The Panel recommends somewhat lower limits for women. **(1)**

Abuse of Prescription Drugs

People 65 and older consume more prescribed and over-the-counter medications than any other age group in the United States. Prescription drug misuse and abuse is prevalent among older adults not only because more drugs are prescribed to them but also because, as with alcohol, aging makes the body more vulnerable to drugs' effects.

Any use of drugs in combination with alcohol carries risk; abuse of these substances raises that risk, and multiple drug abuse raises it even further. For example, chronic alcoholics who use even therapeutic doses of acetaminophen may experience severe hepatotoxicity. Alcohol can increase lithium toxicity and enhance central nervous system depression in persons taking tricyclic antidepressants. High doses of benzodiazepines used in conjunction with alcohol or barbiturates can be lethal. The many possible unfavorable reactions between

prescription drugs and alcohol are summarized in Figure 3-6 in the original guideline document.

Figure 3-6
Drug-Alcohol Interactions and Adverse Effects

Drug	Adverse Effect With Alcohol
Acetaminophen	Severe hepatoxicity with therapeutic doses of acetaminophen in chronic alcoholics
Anticoagulants, oral	Decreased anticoagulant effect with chronic alcohol abuse
Antidepressants, tricyclic	Combined central nervous system depression decreases psychomotor performance, especially in the first week of treatment
Aspirin and other nonsteroidal anti-inflammatory drugs	Increased the possibility of gastritis and gastrointestinal hemorrhage
Barbiturates	Increased central nervous system depression (additive effects)
Benzodiazepines	Increased central nervous system depression (additive effects)
Beta-adrenergic blockers	Masked signs of delirium tremens
Bromocriptine	Combined use increases gastrointestinal side effects
Caffeine	Possible further decreased reaction time
Cephalosporins and Chloramphenicol	Disulfiram-like reaction with some cephalosporins and chloramphenicol
Chloral hydrate	Prolonged hypnotic effect and adverse cardiovascular effects
Cimetidine	Increased central nervous system depressant effect of alcohol
Cycloserine	Increased alcohol effect or convulsions
Digoxin	Decreased digitalis effect
Disulfiram	Abdominal cramps, flushing, vomiting, hypotension, confusion, blurred vision, and psychosis
Guanadrel	Increased sedative effect and orthostatic hypotension
Glutethimide	Additive central nervous system depressant effect
Heparin	Increased bleeding
Hypoglycemics, sulfonylurea	Acutely ingested, alcohol can increase the hypoglycemic effect of sulfonylurea drugs; chronically ingested, it can decrease hypoglycemic effect of these drugs
Tolbutamide, chlorpropamide	Disulfiram-like reaction
Isoniazid	Increased liver toxicity
Ketoconazole, griseofulvin	Disulfiram-like reaction
Lithium	Increased lithium toxicity
Meprobamate	Synergistic central nervous system depression
Methotrexate	Increased hepatic damage in chronic alcoholics
Metronidazole	Disulfiram-like reaction
Nitroglycerin	Possible hypotension
Phenformin	Lactic acidosis (synergism)
Phenothiazines	Additive central nervous system depressant activity
Phenytoin	Acutely ingested, alcohol can increase the toxicity of phenytoin; chronically ingested, it can decrease the anticonvulsant effect of phenytoin
Quinacrine	Disulfiram-like reaction
Tetracyclines	Decreased effect of doxycycline

Source: Korrapati and Vestal, 1995.

Benzodiazepines

Benzodiazepine use for longer than 4 months is not recommended for geriatric patients. **(2)** Furthermore, among the different benzodiazepines, longer acting drugs such as flurazepam (Dalmane) have very long half-lives and are more likely to accumulate than the shorter acting ones. They are also more likely to produce residual sedation and such other adverse effects as decreased attention, memory, cognitive function, and motor coordination, and increased falls or motor vehicle crashes. By contrast, some shorter acting benzodiazepines such as oxazepam (Serax) and lorazepam (Ativan) have very simple metabolic pathways and are not as likely to produce toxic or dependence-inducing effects with chronic dosing. *Because of these side effects, the Panel recommends caution in selecting the most appropriate benzodiazepines for elderly patients.* **(2)**

Sedative/Hypnotics

Aging changes sleep architecture, decreasing the amount of time spent in the deeper levels of sleep (stages three and four) and increasing the number and duration of awakenings during the night. However, these new sleep patterns do not appear to bother most medically healthy older adults who recognize and accept that their sleep will not be as sound or as regular as when they were young. Although benzodiazepines and other sedative/hypnotics can be useful for short-term amelioration of temporary sleep problems, no studies demonstrate their long-term effectiveness beyond 30 continuous nights, and tolerance and dependence develop rapidly. *The Panel recommends that symptomatic treatment of insomnia with medications be limited to 7 to 10 days with frequent monitoring and reevaluation if the prescribed drug will be used for more than 2 to 3 weeks. Intermittent dosing at the smallest possible dose is preferred, and no more than a 30-day supply of hypnotics should be prescribed.* **(1)**

The Panel further recommends that clinicians teach older patients to practice good sleep hygiene rather than prescribe drugs in response to insomnia. **(1)** The former includes regularizing bedtime, restricting daytime naps, using the bedroom only for sleep and sexual activity, avoiding alcohol and caffeine, reducing evening fluid intake and heavy meals, taking some medications in the morning, limiting exercise immediately before retiring, and substituting behavioral relaxation techniques.

Antihistamines

Older persons appear to be more susceptible to adverse anticholinergic effects from antihistamines andd are at increased risk for orthostatic hypotension and central nervous system depression or confusion. In addition, antihistamines and alcohol potentiate one another, further exacerbating the above conditions as well as any problems with balance. Because tolerance also develops within days or weeks, *the Panel recommends that older persons who live alone do not take antihistamines*. **(1)**

Identification, Screening, and Assessment

The Consensus Panel recommends that every 60-year-old should be screened for alcohol and prescription drug abuse as part of his or her regular physical examination. **(2)** However, problems can develop after the screening has been conducted, and concurrent illnesses and other chronic conditions may mask abuse. Although no hard-and-fast rules govern the timing of screening, *the Panel recommends screening or rescreening if certain physical symptoms are present or if the older person is undergoing major life changes or transitions.* **(2)**

Although it is preferable to use standardized screening questionnaires, friendly visitors, Meals-On-Wheels volunteers, caretakers, and health care providers also can interject screening questions into their normal conversations with older, homebound adults. Although the line of questioning will depend on the person's relationship with the older person and the responses given, *the Panel recommends that anyone who is concerned about an older adult's drinking practices try asking direct questions.* **(2)**(Examples of these and of less direct questions appear in Chapter 4 of the original guideline document.)

The Panel recommends that health care providers preface questions about alcohol with a link to a medical condition when screening older people. **(2)** For example, "I'm wondering if alcohol may be the reason why your diabetes isn't responding as it should," or "Sometimes one prescription drug can affect how well another medication is working. Let's go over the drugs you're taking and see if we can figure this problem out." *Do not use stigmatizing terms like* alcoholic *or* drug abuser *during these encounters.* **(2)**

Although it is important to respect the older person's autonomy, in situations where a coherent response is unlikely, collateral participation from family members or friends may be necessary. In this

case, *the screener should first ask for the older adult's permission to question others on his or her behalf.* **(2)**

Instruments

The Panel recommends use of the CAGE Questionnaire and the Michigan Alcohol Screening Test-Geriatric Version (MAST-G) to screen for alcohol use among older adults. **(1)**
The Alcohol Use Disorders Identification Test (AUDIT) is recommended for identifying alcohol problems among older members of ethnic minority groups. **(2)**

Assessment

Substance abuse

The Panel recommends a sequential approach that looks at various dimensions of an older adult's suspected problem in stages, so that unnecessary tests are not conducted. **(1)**
The Panelists recommend the use of two structured assessments with older adults: the substance abuse sections of the Structured Clinical Interview for DSM-III-R (SCID) and the Diagnostic Interview Schedule (DIS) for DSM-IV. **(2)**

Functioning

To identify functional impairments, *the Panel recommends measuring the activities of daily living (ADLs) and the instrumental activities of daily living (IADLs)* with the instruments in Appendix B of the guideline document. **(1)** *Another useful instrument is the SF-36,* a 36-item self-report questionnaire that measures health-related quality of life, including both ADLs and IADLs. **(1)**

Cognitive dysfunction

Patients who have been medically detoxified should not be screened for cognitive dysfunction until several weeks after detoxification is completed, because a patient not fully recovered from detoxification may exhibit some reversible cognitive impairment. **(2)**
The Panel recommends use of the Orientation/Memory/Concentration Test **(1),** which is simple and can be completed in the office. *The Folstein Mini-Mental Status Exam (MMSE) is an acceptable alternative* **(1),** although it can be insensitive to subtle cognitive impairments among older problem drinkers who have recently attained sobriety (past 30-60 days). The MMSE is weak on visual-spatial testing, which is likely to show some abnormality in many recent heavy drinkers. *The draw-a-clock task is a good additional task to complement the MMSE.* **(1)** *The Neurobehavioral Cognitive Status Examination, which includes screening tests of abstract thinking and visual memory (not measured on the MMSE), is also recommended for assessing mental status in this population.* **(1)**
*The Confusion Assessment Method (CAM) is widely used as a brief, sensitive, and reliable screening measure for detecting delirium. **(1)** The Panel recommends that a positive delirium screen be followed by careful clinical diagnostics based on DSM-IV criteria and that any associated cognitive impairment be followed clinically using the MMSE.* **(1)**

Medical status

The Panel recommends that initial medical assessment of older persons should routinely include screening for visual and auditory problems, and any problems discovered should be corrected as quickly as possible. **(2)** To assess the medication use of older adults, *the Panel recommends the "brown bag approach." The practitioner can ask older adults to bring every medication they take in a brown paper bag, including over-the-counter and prescription medications, vitamins, and herbs.* **(1)**

Sleep disorders

The Panel recommends that sleep history be recorded in a systematic way in order to both document the changes in sleep problems over time and to heighten the awareness of sleep hygiene. **(2)**

Depression

The Geriatric Depression Scale (GDS) and the Center for Epidemiological Studies Depression Scale (CES-D), reproduced in Appendix B of the guideline document have been validated in older age groups although not specifically in older adults with addiction problems*. The Panel recommends the CES-D for use in general outpatient settings as a screen for depression among older patients.* **(1)**

Treatment

The Consensus Panel recommends that the least intensive treatment options be explored first with older substance abusers. **(1)** These initial approaches, which can function either as pretreatment strategy or treatment itself, are brief intervention, intervention, and motivational counseling. They may be sufficient to address the problem; if not, they can help move a patient toward specialized treatment.

The Consensus Panel recommends that every reasonable effort be made to ensure that older substance abusers, including problem drinkers, enter treatment. Brief intervention is the recommended first step, supplemented or followed by intervention and motivational interviewing. ***(1)*** Because many older problem drinkers are ashamed about their drinking, intervention strategies need to be nonconfrontational and supportive.

Conducting Brief Interventions

A brief intervention is one or more counseling sessions, which may include motivation for change strategies, patient education, assessment and direct feedback, contracting and goal setting, behavioral modification techniques, and the use of written materials such as self-help manuals. *An older adult-specific brief intervention should include the following steps* **(2):**

1. Customized feedback on screening questions relating to drinking patterns and other health habits such as smoking and nutrition.

2. Discussion of types of drinkers in the United States and where the patient's drinking patterns fit into the population norms for his or her age group.

3. Reasons for drinking. This is particularly important because the practitioner needs to understand the role of alcohol in the context of the older patient's life, including coping with loss and loneliness.

4. Consequences of heavier drinking. Some older patients may experience problems in physical, psychological, or social functioning even though they are drinking below cutoff levels.

5. Reasons to cut down or quit drinking. Maintaining independence, physical health, financial security, and mental capacity can be key motivators in this age group.

6. Sensible drinking limits and strategies for cutting down or quitting. Strategies that are useful in this age group include developing social opportunities that do not involve alcohol, getting reacquainted with hobbies and interests from earlier in life, and pursuing volunteer activities, if possible.

7. Drinking agreement in the form of a prescription. Agreed-upon drinking limits that are signed by the patient and the practitioner are particularly effective in changing drinking patterns.

8. Coping with risky situations. Social isolation, boredom, and negative family interactions can present special problems in this age group.

9. Summary of the session.

If the older problem drinker does not respond to the brief intervention, two other approaches -- intervention and motivational interviewing -- should be considered.

Intervention

In an *intervention*, several significant people in a substance-abusing patient's life confront the patient with their firsthand experiences of his or her drinking or drug use. The formalized intervention process includes a progressive interaction by the counselor with the family or friends for at least 2 days before meeting with the patient.

The Panel recommends the following modifications to interventions for older patients. No more than one or two relatives or close associates should be involved along with the health care provider; having too many people present may be emotionally overwhelming or confusing for the older person. *Inclusion of grandchildren is discouraged*, because many older alcoholics resent their problems being aired in the presence of much younger relatives. **(2)**

Motivational Counseling

Motivational counseling acknowledges differences in readiness and offers an approach for "meeting people where they are" that has proven effective with older adults. **(1)** An understanding and supportive counselor listens respectfully and accepts the older adult's perspective on the situation as a starting point, helps him or her to identify the negative consequences of drinking and prescription drug abuse, helps him or her shift perceptions about the impact of drinking or drug-taking habits, empowers him or her to generate insights about and solutions for his or her problem, and expresses

belief in and support for his or her capacity for change. Motivational counseling is an intensive process that enlists patients in their own recovery by avoiding labels, avoiding confrontation (which usually results in greater defensiveness), accepting ambivalence about the need to change as normal, inviting clients to consider alternative ways of solving problems, and placing the responsibility for change on the client.

Detoxification

Some older patients should be withdrawn from alcohol or from prescription drugs in a hospital setting. Medical safety and removal from continuing access to alcohol or the abused drugs are primary considerations in this decision.

Indicators that inpatient hospital supervision is needed for withdrawal from a prescription drug include the following **(2):**

- A high potential for developing dangerous abstinence symptoms such as a seizure or delirium because the dosage of a benzodiazepine or barbiturate has been particularly high or prolonged and has been discontinued abruptly or because the patient has experienced these serious symptoms at any time previously
- Suicidal ideation or threats
- The presence of other major psychopathology
- Unstable or uncontrolled comorbid medical conditions requiring 24-hour care or parenterally administered medications (e.g., renal disease, diabetes)
- Mixed addictions, including alcohol
- A lack of social supports in the living situation or living alone with continued access to the abused drug(s).

In general, *the Panel recommends that the initial dose of a drug for suppression and management of withdrawal symptoms should be one-third to one-half the usual adult dose, sustained for 24 to 48 hours to observe reactions, and then gradually tapered with close attention to clinical responses*. **(1)**

Treatment Settings

The Panel recommends that patients who are brittle, frail, acutely suicidal, or medically unstable or who need constant one-on-one monitoring receive 24-hour primary medical/psychiatric/nursing inpatient care in medically managed and monitored intensive treatment settings. **(2)**

As part of outpatient treatment, *the Panel recommends drawing the physician into the treatment planning process and enrolling him or her as a player in the recovery network.* (**2)**

The Panel also recommends serving older people who are dependent on psychoactive prescription drugs in flexible, community-oriented programs with case management services rather than in traditional, stand-alone substance abuse treatment facilities with standardized components. **(2)**

Treatment Approaches

The Panel recommends incorporating the following six features into treatment of the older alcohol abuser **(1):**

- Age-specific group treatment that is supportive and nonconfrontational and aims to build or rebuild the patient's self-esteem
- A focus on coping with depression, loneliness, and loss (e.g., death of a spouse, retirement)
- A focus on rebuilding the client's social support network
- A pace and content of treatment appropriate for the older person
- Staff members who are interested and experienced in working with older adults
- Linkages with medical services, services for the aging, and institutional settings for referral into and out of treatment, as well as case management.

Building from these six features, t*he Consensus Panel recommends that treatment programs adhere to the following principles* ***(2****):*

- Treat older people in age-specific settings where feasible
- Create a culture of respect for older clients
- Take a broad, holistic approach to treatment that emphasizes age-specific psychological, social, and health problems
- Keep the treatment program flexible
- Adapt treatment as needed in response to clients' gender.

To help ensure optimal benefits for older adults, *the Consensus Panel recommends that treatment plans weave age-related factors into the contextual framework of the American Society of Addiction Medicine (ASAM) criteria.* **(2)**
The Consensus Panel recommends the following general approaches for effective treatment of older adult substance abusers ***(2):***

- Cognitive-behavioral approaches
- Group-based approaches
- Individual counseling
- Medical/psychiatric approaches
- Marital and family involvement/family therapy
- Case management/community-linked services and outreach.

The Panel recommends that cognitive-behavioral treatment focus on teaching skills necessary for rebuilding the social support network; self-management approaches for overcoming depression, grief, or loneliness; and general problem solving. **(1)**
Within treatment groups, *the Panel recommends that older clients should get more than one opportunity to integrate and act on new information.* **(2)** For example, information on bereavement can be presented in an educational session, then reinforced in therapy. To help participants integrate and understand material*, it may be helpful to expose them to all units of information twice.* **(2)**
Older people in educational groups can receive, integrate, and recall information better if they are given a clear statement of the goal and purpose of the session and an outline of the content to be covered. The leader can post this outline and refer to it throughout the session. The outline may also be distributed for use in personal note-taking and as an aid in review and recall. *Courses and individual sessions should be conceived as building blocks that are added to the base of the older person's life experience and needs. Each session should begin with a review of previously presented materials.* **(2)**
Groups should accommodate clients' sensory decline and deficits by maximizing the use of as many of the clients' senses as possible*. The Panel recommends use of simultaneous visual and audible presentation of material, enlarged print, voice enhancers, and blackboards or flip charts.* **(2)** It is important to recognize clients' physical limitations*. Group sessions should last no longer than about 55 minutes. The area should be well lighted without glare; and interruptions, noise, and superfluous material should be kept to a minimum.* **(2)**
The Panel recommends that counselors providing individual psychotherapy treat older clients in a nonthreatening, supportive manner and assure the client that they will honor the confidentiality of the sessions. **(2)**
Medications used to modify drinking behavior in older adults must take into account age- and disease-related increases in vulnerability to toxic drug side effects, as well as possible adverse interactions with other prescribed medications*. Disulfiram (Antabuse) is not generally recommended by the Panel for use in older patients because of the hazards of the alcohol-disulfiram interaction, as*

well as the toxicity of disulfiram itself. **(1)** Of the other pharmacotherapies for alcohol abuse, naltrexone (ReVia) is well tolerated by older adults and may reduce drinking relapses. **(1)**
Depression for several days or longer immediately after a prolonged drinking episode does not necessarily indicate a true comorbid disorder or the need for antidepressant treatment in most cases, but *when depressive symptoms persist several weeks following cessation of drinking, specific antidepressant treatment is indicated.* **(1)**
The advantages of quitting smoking are clear, even in older adults. *The Panel recommends that efforts to reduce substance abuse among older adults also include help in tobacco smoking cessation*.
Staffing Considerations *The Consensus Panel recommends that the following principles guide staffing choices in substance abuse treatment programs* ***(2)****:*

- Whenever possible, employ staff who have completed training in gerontology
- Employ staff who like working with older adults
- Provide training in empirically demonstrated principles effective with older adults to all staff who will interact with these clients.

Panel members believe that any program that treats even a few older adults should have at least one staff person who is trained in the specialization of gerontology within his or her discipline. This training should consist of at least a graduate certificate program (6- to 12- month) in the subfield of aging commonly called social gerontology. Staff with professional degrees should have a specialization in gerontology, geriatrics, or psychogeriatrics.
Outcomes and Cost Issues In Alcohol Treatment
Outcome assessment is invaluable from both a management and a referral perspective. The providers of treatment, the clinicians and agencies referring patients, and patients themselves need to have information regarding the likely outcomes of treatment. Because treatment options range from brief interventions to structured outpatient and inpatient treatment programs, *the Panel recommends evaluation of outcomes at varying points in the treatment process.* **(1)** Baseline data should be obtained at the beginning of the intervention or treatment; first follow-up evaluations should be conducted 2 weeks to 1 month after the patient leaves the inpatient setting. The literature on patients receiving substance abuse treatment indicates that 60 to 80 percent of people who relapse do so within 3 to 4 months. Therefore, *outpatient outcomes should be assessed no sooner than 3 months and possibly as long as 12 months after treatment.* **(1)**
The Panel recommends that outcome measurement include not only abstinence or reduced consumption but also patterns of alcohol use, alcohol-related problems, physical and emotional health functioning, and quality of life and well-being. **(1)** One of the most widely used measures of physical and emotional health is the Medical Outcomes Study 36-Item Short Form Health Survey (SF-*36). **(1)** Ano*ther measure of psychological distress useful for alcohol outcomes assessment with older adults is the Symptom Checklist-90-Revised (SCL-90-R) and its abbreviated version, the Brief Symptom Inventory (BSI). **(1)** *For measuring quality of life, an important measure for older adults with alcohol problems, the Panel recommends the Quality of Life Interview (QLI)*. **(1)**
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Case Management for AODA

Brief Summary

TITLE:
Comprehensive case management for substance abuse treatment.

SOURCE(S):
Substance Abuse and Mental Health Services Administration (SAMHSA). Comprehensive case management for substance abuse treatment. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1998. 122 p. (Treatment improvement protocol (TIP) series; no. 27). [180 references]

ADAPTATION:
Not applicable: Guideline was not adapted from another source.

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MAJOR RECOMMENDATIONS:
Case management has been variously classified as a skill group, a core function, service coordination, or a network of "friendly neighbors." Although it defies precise definition, case management generally can be described as a coordinated approach to the delivery of health, substance abuse, mental health, and social services, linking clients with appropriate services to address specific needs and achieve stated goals. The Consensus Panel that developed this TIP believes that case management lends itself to the treatment of substance abuse, particularly for clients with other disorders and conditions who require multiple services over extended periods of time and who face difficulty in gaining access to those services. The guideline document details the factors that programs should consider as they decide to implement case management or modify their current case management activities.

Research suggests two reasons why case management is effective as an adjunct to substance abuse treatment. First, retention in treatment is associated with better outcomes, and a principal goal of case management is to keep clients engaged in treatment and moving toward recovery. Second, treatment may be more likely to succeed when a client's other problems are addressed concurrently with substance abuse. Case management focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a client's life. Comprehensive substance abuse treatment often requires that clients move to different levels of care or systems; case management facilitates such movement.

Any definition of case management will be contextual, depending on who is implementing the program. Perhaps a more helpful way to understand it is to examine the functions that generally comprise case management: (1) assessment, (2) planning, (3) linkage, (4) monitoring, and (5) advocacy.

Case Management and Substance Abuse Treatment

When implemented to its fullest, case management will enhance the scope of addictions treatment and the recovery continuum. A treatment professional utilizing case management will

- Provide the client a single point of contact for multiple health and social services systems
- Advocate for the client
- Be flexible, community-based, and client-oriented

- Assist the client with needs generally thought to be outside the realm of substance abuse treatment

To provide optimal services for clients, a treatment professional should possess particular knowledge, skills, and attitudes including

- Understanding various models and theories of addiction and other problems related to substance abuse
- Ability to describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems
- Ability to recognize the importance of family, social networks, community systems, and self-help groups in the treatment and recovery process
- Understanding the variety of insurance and health maintenance options available and the importance of helping clients access those benefits
- Understanding diverse cultures and incorporating the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice
- Understanding the value of an interdisciplinary approach to addiction treatment

In addition to the above competencies, treatment professionals must have skills relating to interagency functioning, negotiating, and advocacy. The Center for Substance Abuse Treatment's (CSAT's) Addiction Technology Transfer Centers classify referral and service coordination basic case management functions as core competencies for substance abuse treatment providers.

The Substance Abuse Treatment Continuum and Functions of Case Management

The continuum of substance abuse treatment ranges from case finding and pretreatment to primary treatment to aftercare. Although there are distinct goals and treatment activities at each point on the continuum, rarely do clients' needs fit neatly into any one area at a given time; case management serves to span client needs and program structure. Substance abuse treatment and case management functions differ in that treatment involves activities that help substance abusers recognize their problems, acquire the motivation and tools to stay abstinent, and use the acquired tools; case management focuses on helping the substance abuser acquire needed resources. Case management supports a client as he moves through the recovery continuum and reinforces treatment goals.

Interagency Case Management

The goal of interagency case management is to expand the network of services available to clients. All organizations have boundaries to what they can do, and case managers or "boundary spanners" transcend them to facilitate interactions among agencies. In the field of substance abuse, three interagency models have been identified. In the *single agency* model, the case manager personally establishes a series of distinct relationships on an as-needed basis with counterparts in other agencies. In the *informal partnership* model, staff members from several agencies work as a collaborative team, often constituted case by case; *the formal consortium* binds case managers and service providers through formal written agreements. Clearly defined roles are essential to all three models to ensure that services are coordinated and relevant gaps addressed.

Although informal exchange or "social service bartering" among different agencies is intrinsic to case management, a more formalized connection among agencies sometimes may be required. Examples include memoranda of understanding and interagency agreements and contracts; each of these methods for formalizing expectations can be used in single agency models, informal partnerships, and formal consortia.

To be successful, a case management plan must thoroughly and critically examine community resources to determine what forms of assistance are available and how case management efforts can help clients attain necessary assistance. Many communities have published directories of social, health, welfare, housing, vocational, and other service organizations to help case management programs identify resources, possible provider linkages, and potential gaps in services for their

clients. Although such directories are a good starting point, it is important to follow up on the listings to ensure they are still accurate and will be of use to the client.

The Environmental Assessment

Exploring the environment in which an agency operates is crucial to determining the feasibility of an interagency effort. Analysis of the community environment will enhance understanding of the changes that occur among clients, within the program, and in the community. Case management takes place within a dynamic social service environment in which agencies are in constant flux. Programs considering interagency efforts must devise strategies to respond to change while providing continuity for the client. Regular reevaluation helps ensure continued relevance; community service provider networks or consortia are particularly effective in sharing information about changes and developments.

Potential Conflicts

Whenever agencies or service providers work together, the potential for conflict exists. Areas of tension may be present from the very onset of the collaboration. For example, a new project may be viewed by established social service agencies as competition for scarce resources. Sometimes social pressures or the need to maximize resources can force public agencies into joint ventures even if they do not mesh well or have a history of being service competitors. Tensions can also develop in the course of delivering services; for example, interagency collaboration may result in a client having two case managers. Recognizing potential triggers for conflict is a necessary first step in developing a system to handle them. When problems do arise, case managers and other agency personnel can use both informal and formal communication to clarify issues, regain perspective, and refocus the interagency case management process.

Evaluation and Quality Assurance of Case Management Services

Substance abuse treatment programs, including those that receive public funding, are increasingly operating in a managed care environment. In such an environment, policy and clinical decisionmaking rely on outcome data that traditionally describe the impact of case management and substance abuse treatment interventions in the context of services used and money spent. An additional demand for data comes from public and private payers who want services linked to specific outcomes.

To gauge the effectiveness of case management, indicators of "success" must be defined by the substance abuse program and its stakeholders (including funding and regulatory agencies). In documenting a case management effort, it is necessary to establish *benchmarks* to measure the case management process, for example, recording how often a client shows up at treatment. Once the benchmarks are defined in measurable terms, the next step is to develop and implement a method for measuring practice; that is, to answer the questions, "What are case managers doing, and how does their practice conform to the benchmarks?" Methods of such documentation include

- Maintenance of a simple staff log procedure that measures case managers' activities by contact
- Reviews of case manager client records to evaluate how service planning and referrals adhere to benchmarks
- Interviews or surveys of case managers or clients and their family members to collect information on activities in which case managers engage, to identify how clients' and case managers' views of case management activities differ
- Analysis of data from the agency's management information system (to examine patterns on type, number, and duration of case manager contacts with different target populations).

Measuring System Outcomes

System outcomes are particularly important in a managed care environment, where overall use of expensive services such as hospitalization and residential treatment is strictly monitored. System outcomes can measure cost savings and quality of care: For example, continuity of care is an appropriate measure for a client at risk for relapse after detoxification and before entry into outpatient treatment. Tracking clients within a comprehensive service agency or analyzing data on costs and encounters within a network of agencies are two methods for measuring system outcomes. For such analyses, a computerized management information system (MIS) is essential.

Measuring Client Outcomes

Although "evaluation" is generally considered worthwhile, there is little agreement about the measurement and documentation of specific outcomes for individual clients. Some view a single measure such as sobriety to be the only meaningful indicator of success; others believe success should be gauged against a range of factors, including reduced substance use, improved family functioning, and fewer encounters with the criminal justice system. Until the debate is resolved, programs should identify treatment objectives and extrapolate from them the outcome variables they want to measure.

Anticipating Quality Assurance Data Needs

The types of data required for an evaluation of case management, how the data are collected, and the manner in which data are put to use vary among different stakeholders. It is important to understand the types of data that various stakeholders need to evaluate the program. Structured feedback loops should be established to ensure that the gathered data are returned to various stakeholders in some meaningful way so that they have an impact on shaping future program development (and future data needs). One of the benefits of the case management approach is that it can be adapted to meet the sometimes contradictory needs of the various stakeholders.

Management Information Systems

A management information system contains all of the case management services information and allows stakeholders to access it. In evaluating a MIS, local programs should

- Determine how to use data already routinely collected by a statewide MIS or a managed care company-based MIS, saving the program from duplicating primary data collection
- Develop or enhance a program-level MIS that tracks data the program needs locally
- Integrate with other computer-based or paper-based systems
- Supply data required by third party payer and governmental bodies

All staff members of a specific program should be stakeholders in the MIS, which increases both system accuracy and the likelihood that a broad array of staff members will use it. If an agency does not have the resources to develop a sophisticated system, it should be able to automate at least a minimum amount of client information through commercially available software. When designing today's MIS, the data requirements of managed care organizations must be addressed.

Future Research

Research centered on case management and the substance abuse field is limited, thus offering local substance abuse programs the opportunity to make significant contributions to the field. Suggested directions for future research include the following:

- Key ingredients of successful programs, especially for hard-to-reach populations
- Relative cost-effectiveness of particular case management models, including cost outcome results within systems incorporating full parity of substance abuse with other health care; outcome results when a full continuum of care is available to patients; and outcome results associated with use of standardized guidelines for placement, continued stay, and discharge for substance abuse patients
- Improved methodology to investigate research questions in "real world" settings
- Development of brief versions of valid and reliable research outcome instrumentation
- The effect of particular forms of case management on societal costs of substance abuse and its treatment
- Cost shifting among health, behavioral health, criminal justice, and other systems that can be accessed by the target population
- Creative ways to use secondary data sets (such as Medicaid and Medicare) to determine trends and patterns of care
- Research questions from broader sociological or multidisciplinary perspectives

Case Management for Clients With Special Needs
Case management is especially appropriate for substance abusers with special treatment needs, related to such issues as HIV infection or AIDS, mental illness, chronic and acute health problems, poverty, homelessness, responsibility for parenting young children, social and developmental problems associated with adolescence and advanced age, involvement with illegal activities, physical disabilities, and sexual orientation. Ideally, a case manager will possess all the expertise and skills needed to treat the many special needs she confronts, but this is unlikely understanding the ramifications of even one special need can be a staggering task. In the absence of such comprehensive knowledge, a case manager should have a basic foundation of attitudes and skills for delivering services to "special needs clients." The case manager should

- Make every effort to be competent in the special circumstances that affect clients typically referred to a particular substance abuse treatment program
- Understand the range of clients' reactions to the challenges associated with particular special circumstances
- Remain aware of the limits of his own knowledge and expertise
- Evaluate personal beliefs and biases about clients who have special problems or needs
- Maintain an open attitude toward seeking and accepting assistance on behalf of a client
- Know where additional information on special problems can be accessed

Funding Under Managed Care
Whatever treatment providers' attitudes toward managed care, they will have to accept that it is the new paradigm for health care. Well over one-half of the States are currently in the process of adopting some form of managed care for providing public-sector behavioral health care services. Many have already received Federal waivers to implement Medicaid managed behavioral health programs, and other waivers are planned or pending. Managed care has changed the context in which substance abuse treatment services are delivered, and substance abuse programs must prepare to function within this new environment if case management is to survive.
Treatment providers using case management may not only survive but actually thrive under managed care. Many managed care organizations (MCOs) reimburse for case management, so it behooves providers to prove that their brand of case management should be covered. The program should develop a comprehensive case management system with the flexibility and resources necessary to eventually show tangible savings.
To adapt to this new way of doing business, treatment programs must assess how they use case management and appraise their readiness to operate in a managed care environment. One way providers can thrive under managed care is to position themselves and their case management services in a competitive market by identifying market niches, such as clients with HIV/AIDS, criminal justice clients, or older clients.
As MCOs increasingly reimburse for case management, licensing requirements are becoming stricter. The trend is toward case managers who have advanced degrees. Accreditation standards will also tighten under managed care.
In short, there are many reasons for substance abuse treatment providers to adopt case management or to formalize their existing case management activities. This will not necessarily mean an upheaval, as many programs are already helping clients navigate their other, non-substance abuse problems. This TIP equips providers with the knowledge they need to fully serve their clients at the same time they conform to the changing health care system.
DEVELOPER(S):
Substance Abuse and Mental Health Services Administration (U.S.) (SAMHSA) - Federal Government Agency [U.S.]
COMMITTEE: Treatment Improvement Protocol (TIP) Series 27 Consensus Panel
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Brief Interventions And Brief Therapies for AODA

Brief Summary

TITLE:
Brief interventions and brief therapies for substance abuse.

SOURCE(S):
Treatment Improvement Protocol Series 34 Consensus Panel. Brief interventions and brief therapies for substance abuse. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1999. (Treatment improvement protocol (TIP) series; no. 34). [583 references]

ADAPTATION:
Not applicable: Guideline was not adapted from another source.

RELEASE DATE:
1999

MAJOR RECOMMENDATIONS:
The Consensus Panel's recommendations summarized below are based on both research and clinical experience. Those supported by scientific evidence are followed by (1); clinically based recommendations are marked (2).

Brief Interventions

Brief interventions are those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse, either by natural, client-directed means or by seeking additional substance abuse treatment.

A brief intervention, however, is only one of many tools available to clinicians. It is not a substitute for care for clients with a high level of dependency. It can, however, be used to engage clients *who need specialized treatment* in specific aspects of treatment programs, such as attending group therapy or Alcoholics Anonymous (AA) meetings.

- The Consensus Panel believes that brief interventions can be an effective addition to substance abuse treatment programs. *These approaches can be particularly useful in treatment settings when they are used to address specific targeted client behaviors and issues in the treatment process that can be difficult to change using standard treatment approaches* (2).

- Variations of brief interventions have been found to be effective both for motivating alcohol-dependent individuals to enter long-term alcohol treatment and for treating some alcohol-dependent persons (1).

- The Consensus Panel recommends that programs use quality assurance improvement projects to determine whether the use of a brief intervention or therapy in specific treatment situations is enhancing treatment (2).

- The Consensus Panel recommends that agencies allocate counselor training time and resources to these modalities. It anticipates that brief interventions will help agencies meet the increasing demands of the managed care industry and fill the gaps that have been left in client care (2).

- Substance abuse treatment personnel should collaborate with other providers (e.g., primary care providers, employee assistance program, wellness clinic staff, etc.) in developing plans that include both brief interventions and more intensive care to help keep clients focused on treatment and recovery (2).

Goals of brief interventions

The basic goal of any brief intervention is to reduce the risk of harm that could result from continued use of substances. The specific goal for each individual client is determined by his consumption pattern, the consequences of his use, and the setting in which the brief intervention is delivered.

- Focusing on intermediate goals allows for more immediate success in the intervention and treatment process, whatever the long-term goals may be. Intermediate goals might include quitting one substance, decreasing frequency of use, or attending a meeting. Immediate successes are important to keep the client motivated (2).

- When conducting a brief intervention, the clinician should set aside the final treatment goal (e.g., accepting responsibility for one's own recovery) to focus on a single behavioral objective. Once this objective is established, a brief intervention can be used to help reach it (2).

Components of brief interventions

There are six elements that are critical for effective brief interventions (1). The acronym FRAMES was coined to summarize these six components:

- **F**eedback is given to the individual about personal risk or impairment.
- **R**esponsibility for change is placed on the participant.
- **A**dvice to change is given by the clinician.
- **M**enu of alternative self-help or treatment options is offered to the participant.
- **E**mpathic style is used by the counselor.
- **S**elf-efficacy or optimistic empowerment is engendered in the participant.

A brief intervention consists of five basic steps that incorporate FRAMES and remain consistent regardless of the number of sessions or the length of the intervention:

1. Introducing the issues in the context of the client's health.
2. Screening, evaluating, and assessing.
3. Providing feedback.
4. Talking about change and setting goals.
5. Summarizing and reaching closure.

Providers may not have to use all five of these components in any given session with a client. However, before eliminating steps in the brief intervention process there should be a well-defined reason for doing so (2).

Essential knowledge and skills for brief interventions

Providing effective brief interventions requires the clinician to possess certain knowledge, skills, and abilities. The following are four essential skills (2):

1. An overall attitude of understanding and acceptance
2. Counseling skills such as active listening and helping clients explore and resolve ambivalence

3. A focus on intermediate goals

4. A working knowledge of the stages-of-change through which a client moves when thinking about, beginning, and trying to maintain new behavior

Brief Therapies

Brief therapy is a systematic, focused process that relies on assessment, client engagement, and rapid implementation of change strategies. The brief therapies presented in this Treatment Improvement Protocol should be seen as separate modalities of treatment, not episodic forms of long-term therapy.

Brief therapies usually feature more (as well as longer) sessions than brief interventions. The duration of brief therapies is reported to be anywhere from 1 to 40 sessions, with the typical therapy lasting between 6 and 20 sessions.

Brief therapies also differ from brief interventions in that their goal is to provide clients with tools to change basic attitudes and handle a variety of underlying problems. Brief therapy differs from longer term therapy in that it focuses more on the present, downplays psychic causality, emphasizes the effective use of therapeutic tools in a shorter time, and focuses on a specific behavioral change rather than large-scale or pervasive change.

Research concerning relative effectiveness of brief versus longer term therapies for a variety of presenting complaints is mixed. However, there is evidence suggesting that brief therapies are often as effective as lengthier treatments for certain populations.

- The best outcomes for brief therapy may depend on clinician skills, comprehensive assessments, and selective criteria for eligibility. Using selective criteria in prescribing brief therapy is critical, since many clients will not meet its eligibility requirements (2).

- Brief therapy for substance abuse treatment is a valuable approach, but it should *not* be considered a standard of care for all populations (1). The Consensus Panel hopes that brief therapy will be adequately investigated in each case before managed care companies and third-party payors decide it is the only modality for which they will pay.

- Brief interventions and brief therapies are well suited for clients who may not be willing or able to expend the significant personal and financial resources necessary to complete more intensive, longer term treatments (2).

- Both research and clinical expertise indicate that individuals who are functioning in society but have patterns of excessive or abusive substance use are unlikely to respond positively to some forms of traditional treatment, but some of the briefer approaches to intervention and therapy can be extremely useful clinical tools in their treatment (1).

When to use brief therapy

Determining when to use a particular type of brief therapy is an important consideration for counselors and therapists. The Panel recommends that client needs and the suitability of brief therapy be evaluated on a case-by-case basis (2). Some criteria for considering the appropriateness of brief therapy for clients include:

- Dual diagnosis issues

- The range and severity of presenting problems

- The duration of substance dependence

- Availability of familial and community supports

- The level and type of influence from peers, family, and community

- Previous treatment or attempts at recovery

- The level of client motivation
- The clarity of the client's short- and long-term goals
- The client's belief in the value of brief therapy
- The numbers of clients needing treatment

The following criteria are derived from Panel members' clinical experience:

- Less severe substance dependence, as measured by an instrument like the Addiction Severity Index (ASI)
- Level of past trauma affecting the client's substance abuse
- Insufficient resources available for more prolonged therapy
- Limited amount of time available for treatment
- Presence of coexisting medical or mental health diagnoses
- Large numbers of clients needing treatment leading to waiting lists for specialized treatment

The Consensus Panel also notes that

- Planned brief therapy can be adapted as part of a course of serial or intermittent therapy. When doing this, the therapist conceives of long-term treatment as a number of shorter treatments, which require the client's problems to be addressed serially rather than concurrently (1).
- Brief therapies will be most effective with clients whose problems are of short duration and who have strong ties to family, work, and community. However, a number of other conditions, such as limited client resources, may also dictate the use of brief therapy (2).
- It is essential to learn the client's perceived obstacles to engaging in treatment as well as to identify any dysfunctional beliefs that could sabotage the engagement process. The critical factor in determining an individual's response is the client's self-perception and associated emotions (1).

Components of effective brief therapy

While there are a variety of different schools of brief therapy available to the clinician, all forms of brief therapy share some common characteristics (2):

- They are either problem focused or solution focused--they target the symptom, not its causes.
- They clearly define goals related to a specific change or behavior.
- They should be understandable to both client and clinician.
- They should produce immediate results.
- They can be easily influenced by the personality and counseling style of the therapist.
- They rely on rapid establishment of a strong working relationship between client and therapist.
- The therapeutic style is highly active, empathic, and sometimes directive.

- Responsibility for change is placed clearly on the client.
- Early in the process, the focus is to help the client enhance his self-efficacy and understand that change is possible.
- Termination is discussed from the beginning.
- Outcomes are measurable.

Screening and assessment

Screening and assessment are critical initial steps in brief therapy. Screening is a process in which clients are identified according to characteristics that indicate they are possibly abusing substances. Screening identifies the need for more in-depth assessment but is not an adequate substitute for complete assessment.

Assessment is a more extensive process that involves a broad analysis of the factors contributing to and maintaining a client's substance abuse, the severity of the problem, and the variety of consequences associated with it. Screening and assessment procedures for brief therapy do not differ significantly from those used for lengthier treatments.

- Clinicians can use a variety of brief assessment instruments, many of which are free. These instruments should be supplemented in the first session by a clinical assessment interview that covers current use patterns, history of substance use, consequences of substance abuse, coexisting psychiatric disorders, major medical problems and health status, education and employment status, support mechanisms, client strengths and situational advantages, and family history (2).
- The screening and assessment process should determine whether the client's substance abuse problem is suitable for a brief therapy approach (2).
- Assessment is critical not only before beginning brief therapy but also as an ongoing part of the process (2).
- Therapists who primarily provide brief therapy should be adept at determining early in the assessment process which client needs or goals are appropriate to address. Related to this, and equally important, the therapist must establish relationships that facilitate the client's referral when her needs or goals cannot be met through brief therapy (2).

The first session

In the first session, the main goals for the therapist are to gain a broad understanding of the client's presenting problems, begin to establish rapport and an effective working relationship, and implement an initial intervention, however small.

1. Counselors should gather as much information as possible about a client before the first counseling session. However, when gathering information about a client from other sources, counselors must be sensitive to confidentiality and client consent issues (2).
2. Therapists should identify and discuss the goals of brief therapy with the client early in treatment, preferably in the first session (2).
3. Although abstinence is an optimal clinical goal, it still must be negotiated with the client (at least in outpatient treatment settings). Abstinence as a goal is not necessarily the sole admission requirement for treatment, and the therapist may have to accept an alternative goal, such as decreased substance use, in order to engage the client effectively (2).
4. The provider of brief therapy must accomplish certain critical tasks during the first session (2), including:

- Producing rapid engagement
- Identifying, focusing, and prioritizing problems
- Working with the client to develop a treatment plan and possible solutions for substance abuse problems
- Negotiating the approach toward change with the client (which may involve a contract between client and therapist)
- Eliciting client concerns about problems and solutions
- Understanding client expectations
- Explaining the structural framework of brief therapy, including the process and its limits (i.e., those items not within the scope of that treatment segment or the agency's work)
- Making referrals for critical needs that have been identified but cannot be met within the treatment setting

Maintenance strategies, termination of therapy, and follow-up

Maintenance strategies must be built into the treatment design from the beginning. A practitioner of brief therapy must continue to provide support, feedback, and assistance in setting realistic goals. Also, the therapist should help the client identify relapse triggers and situations that could endanger continued sobriety (2).

Strategies to help clients maintain the progress made during brief therapy include the following (2):

- Educating the client about the chronic, relapsing nature of substance abuse
- Considering which circumstances might cause a client to return to treatment and planning how to address them
- Reviewing problems that emerged but were not addressed in treatment and helping the client develop a plan for addressing them in the future
- Developing strategies for identifying and coping with high-risk situations or the reemergence of substance abuse behaviors
- Teaching the client how to capitalize on personal strengths
- Emphasizing client self-sufficiency and teaching self-reinforcement techniques
- Developing a plan for future support, including mutual help groups, family support, and community support

Termination of therapy should always be planned in advance (2). When the client has made the agreed-upon behavior changes and has resolved some problems, the therapist should prepare to end the brief therapy. If a client progresses more quickly than anticipated, it is not necessary to complete the full number of sessions.

Therapist characteristics

Therapists will benefit from a firm grounding in theory and a broad technical knowledge of the many different approaches to brief therapy that are available (2). When appropriate, elements of different brief therapies may be combined to provide successful outcomes. However, it is important to remember that the effectiveness of highly defined interventions (e.g., workbook-driven interventions) used in some behavioral therapies depends on administration of the entire regimen.

- The therapist must use caution in combining and mingling certain techniques and must be sensitive to the cultural context within which therapies are integrated (2).

- Therapists should be sufficiently trained in the therapies they are using and should not rely solely on a manual such as this to learn those therapies (2).

- Training for brief therapies, in contrast to the training necessary to conduct brief interventions, requires months to years and usually results in a specialist degree or certification. The Consensus Panel recommends that anyone seeking to practice the therapies outlined here should receive more thorough training appropriate to the type of therapy being delivered (2).

- Providers of brief therapy should be able to focus effectively on identifying and adhering to specific therapeutic goals in treatment (2).

- Providers who practice brief therapy should be able to distill approaches from longer term therapies and apply them within the parameters of brief therapy (2).

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy represents the integration of principles derived from behavioral theory, cognitive social learning theory, and cognitive therapy, and it provides the basis for a more inclusive and comprehensive approach to treating substance abuse disorders. Cognitive-behavioral therapy can be used by properly licensed and trained mental health practitioners, even if they have limited experience with this type of therapy--either as a cost-effective primary approach or in conjunction with other therapies or a 12-Step program. Cognitive-behavioral therapy can be also used early in and throughout the treatment process whenever the therapist feels it is important to examine a client's inaccurate or unproductive thinking that could lead to risky or negative behaviors (2).

Cognitive-behavioral therapy is generally not appropriate for certain clients, namely, those

- Who have psychotic or bipolar disorders and are not stabilized on medication

- Who have no stable living arrangements

- Who are not medically stable (as assessed by a pretreatment physical examination) (2)

Cognitive-behavioral techniques

The cognitive-behavioral model assumes that substance abusers are deficient in coping skills, choose not to use those they have, or are inhibited from doing so. It also assumes that over the course of time, substance abusers develop a particular set of effect expectancies based on their observations of peers and significant others abusing substances to try to cope with difficult situations, as well as through their own experiences of the positive effects of substances.

1. Cognitive-behavioral therapy is generally effective because it helps clients recognize the situations in which they are likely to use substances, find ways of avoiding those situations, and cope more effectively with the variety of situations, feelings, and behaviors related to their substance abuse (2). To achieve these therapeutic goals, cognitive-behavioral therapy incorporates three core elements:

    - ***Functional analysis*** This analysis attempts to identify the antecedents and consequences of substance abuse behavior, which serve as triggering and maintaining factors.

    - ***Coping skills training*** A major component in cognitive-behavioral therapy is the development of appropriate coping skills.

    - ***Relapse prevention*** These approaches rely heavily on functional analyses, identification of high-risk relapse situations, and coping skills training, but

also incorporate additional features. These approaches attempt to deal directly with a number of the cognitions involved in the relapse process and focus on helping the individual gain a more positive self-efficacy.

2. Overall, behavioral, cognitive, and cognitive-behavioral interventions are effective, can be used with a wide range of substance abusers, and can be conducted within the timeframe of brief therapies (1).

3. A broad range of cognitions will be evaluated in cognitive-behavioral therapy, including attributions, appraisals, self-efficacy expectancies, and substance-related effect expectancies (2).

Strategic/Interactional Therapies

Strategic/interactional therapies attempt to identify the client's strengths and actively create personal and environmental situations in which success can be achieved. The primary strength of strategic/interactional approaches is that they shift the focus from the client's weaknesses to his strengths.

The strategic/interactional model has been widely used and successfully tested on persons with serious and persistent mental illnesses (1). Although the research to date on these therapies (using nonexperimental designs) has not focused on substance abuse disorders, the use of these therapies in treating substance abuse disorders is growing.

The Consensus Panel believes that these therapeutic approaches are potentially useful for clients with substance abuse disorders and should be introduced to offer new knowledge and techniques for treatment providers to consider (2).

Using strategic/interactional therapies

No matter which type of strategic/interactional therapy is used, this approach can help to

- Define the situation that contributes to substance abuse in terms meaningful to the client (2).

- Identify steps needed to control or end substance abuse (2).

- Heal the family system so it can better support change (2).

- Maintain behaviors that will help control substance abuse (2).

- Respond to situations in which the client has returned to substance use after a period of abstinence (2).

- Strategic/interactional approaches are most useful in learning how the client's relationships deter or contribute to substance abuse (2).

- Shifting power relationships (2).

- Addressing fears (2).

Most forms of strategic/interactional therapies are brief by the definition used in this Treatment Improvement Protocol. Strategic/interactional therapies normally require 6 to 10 sessions, with 6 being most common.

Humanistic and Existential Therapies

Humanistic and existential psychotherapies use a wide range of approaches to the planning and treatment of substance abuse disorders. They are, however, united by an emphasis on understanding human experience and a focus on the client rather than the symptom. Humanistic and existential approaches share a belief that people have the capacity for self-awareness and choice. However, the two schools come to this belief through different theories.

Humanistic and existential therapeutic approaches may be particularly appropriate for short-term substance abuse treatment because they tend to facilitate therapeutic rapport, increase self-awareness, focus on potential inner resources, and establish the client as the person responsible for recovery. Thus, clients may be more likely to see beyond the limitations of

short-term treatment and envision recovery as a lifelong process of working to reach their full potential (2).

Using humanistic and existential therapies

Many aspects of humanistic and existential approaches (including empathy, encouragement of affect, reflective listening, and acceptance of the client's subjective experience) can be useful in any type of brief therapy. They help establish rapport and provide grounds for meaningful engagement with all aspects of the treatment process (2).

Humanistic and existential approaches can be used at all stages of recovery in creating a foundation of respect for clients and mutual acceptance of the significance of their experiences (2). There are, however, some therapeutic moments that lend themselves more readily to one or more specific approaches.

- *Client-centered* therapy can be used immediately to establish rapport and to clarify issues throughout the session (2).

- *Existential* therapy may be used most effectively when a client has access to emotional experiences or when obstacles must be overcome to facilitate a client's entry into or continuation of recovery (e.g., to get someone who insists on remaining helpless to accept responsibility for her actions) (2).

- *Narrative* therapy can be used to help the client conceptualize treatment as an opportunity to assume authorship and begin a "new chapter" in life (2).

- *Gestalt* approaches can be used throughout therapy to facilitate a genuine encounter with the therapist and the client's own experience (2).

- *Transpersonal* therapy can enhance spiritual development by focusing on the intangible aspects of human experience and awareness of unrealized spiritual capacity (2).

Using a humanistic or existential therapy framework, the therapist can offer episodic treatment, with a treatment plan that focuses on the client's tasks and experiences between sessions (2).

For many clients, momentary circumstances and other problems surrounding substance abuse may seem more pressing than notions of integration, spirituality, and existential growth, which may be too remote from their immediate situation to be effective. In such instances, humanistic and existential approaches can help clients focus on the fact that they do indeed make decisions about substance abuse and are responsible for their own recovery (2).

Psychodynamic Therapies

Psychodynamic therapy focuses on unconscious processes as they are manifested in the client's present behavior. The goals of psychodynamic therapy are client self-awareness and understanding of the past's influence on present behavior. In its brief form, a psychodynamic approach enables the client to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest themselves in the need and/or desire to abuse substances.

Several of the brief forms of psychodynamic therapy are less appropriate for use with persons with substance abuse disorders, partly because their altered perceptions make it difficult to achieve insight and problem resolution. However, many psychodynamic therapists use forms of brief psychodynamic therapy with substance-abusing clients in conjunction with traditional substance abuse treatment programs or as the sole therapy for clients with coexisting disorders (2).

Although there is some disagreement in the details, psychodynamic brief therapy is generally thought more suitable for (2):

- Those who have coexisting psychopathology with their substance abuse disorder

- Those who do not need or who have completed inpatient hospitalization or detoxification

- Those whose recovery is stable
- Those who do not have organic brain damage or other limitations to their mental capacity

Integrating psychodynamic concepts into substance abuse treatment

Most therapists agree that people with substance abuse disorders comprise a special population, one that often requires more than one approach if treatment is to be successful. Therapists whose orientations are not necessarily psychodynamic may still find these techniques and approaches useful, and therapists whose approaches are psychodynamic may be more effective if they conduct psychotherapy in a way that complements the full range of services for clients with substance abuse disorders (2).

Family Therapy

For many individuals with substance abuse disorders, interactions with their family of origin, as well as their current family, set the patterns and dynamics for their problems with substances. Furthermore, family member interactions with the substance abuser can either perpetuate and aggravate the problem or substantially assist in resolving it. Family therapy is particularly appropriate when the client exhibits signs that his substance abuse is strongly influenced by family members' behaviors or communications with them (2).

Family involvement is often critical to success in treating many substance abuse disorders--most obviously in cases where the family is part of the problem (2).

Family therapy can be used to

- Focus on the expectation of change within the family (which may involve multiple adjustments)
- Test new patterns of behavior
- Teach how a family system works--how the family supports symptoms and maintains needed roles
- Elicit the strengths of every family member
- Explore the meaning of the substance abuse disorder within the family

Appropriateness of brief family therapy

Long-term family therapy is not usually necessary for the treatment of substance abuse disorders. While family therapy may be very helpful in the initial stages of treatment, it is often easier to continue to help an individual work within the family system through subsequent individual therapy (2).

Short-term family therapy is an option that could be used in the following circumstances (2):

- When resolving a specific problem in the family and working toward a solution
- When the therapeutic goals do not require in-depth, multigenerational family history, but rather a focus on present interactions
- When the family as a whole can benefit from teaching and communication to better understand some aspect of the substance abuse disorder

Definitions of "family"

Family therapy can involve a network that extends beyond the immediate family, involves only a few members of the family system, or even deals with several families at once (2). The definition of "family" varies in different cultures and situations and should be defined by the client.

Therapists can "create" a family by drawing on the client's network of significant contacts (2). A more important question than whether the client is living with a family is, "Can the client's problem be seen as having a relational (involving two or more people) component?"

Using brief family therapies

In order to promote change successfully within a family system, the therapist will need the family's permission to enter the family space and share their closely held confidences. The

therapy, however, will work best if it varies according to the cultural background of the family (1).
Most family therapy is conducted on a short-term basis. Sessions are typically 90 minutes to 2 hours in length. The preferred timeline for family therapy is not more than 2 sessions per week (except in residential settings), to allow time to practice new behaviors and experience change. Therapy may consist of as few as 6 or as many as 10 sessions, depending on the purpose and goals of the intervention.

Group Therapy

Group psychotherapy is one of the most common modalities for treatment of substance abuse disorders. Group therapy is defined as a meeting of two or more people for a common therapeutic purpose or to achieve a common goal. It differs from family therapy in that the therapist creates open- and closed-ended groups of people previously unknown to each other.

Appropriateness of group therapy

Group psychotherapy can be extremely beneficial to individuals with substance abuse problems (2). It gives them the opportunity to see the progression of abuse and dependency in themselves and others; it also provides an opportunity to experience personal success and the success of other group members in an atmosphere of support and hope.

Use of psychodrama techniques in a group setting

Psychodrama has long been effectively used with substance-abusing clients in a group setting. Psychodrama can be used with different models of group therapy. It offers persons with substance abuse disorders an opportunity to better understand past and present experiences--and how past experiences influence their present lives (2).

Using time-limited group therapy

The focus of time-limited therapeutic groups varies a great deal according to the model chosen by the therapist. Yet some generalizations can be made about several dimensions of the manner in which brief group therapy is implemented.
Client preparation is particularly important in any time-limited group experience. Clients should be thoroughly assessed before their entry into a group for therapy (2). Group participants should be given a thorough explanation of group expectations.
The preferred timeline for time-limited group therapy is not more than 2 sessions per week (except in the residential settings), with as few as 6 sessions in all, or as many as 12, depending on the purpose and goals of the group.
Sessions are typically 1 1/2 to 2 hours in length. Residential programs usually have more frequent sessions.
Group process therapy is most effective if participants have had time to find their roles in a group, to "act" these roles, and to learn from them. The group needs time to define its identity, develop cohesion, and become a safe environment in which there is enough trust for participants to reveal themselves (2).

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To Health and Wellness Professionals and Practitioners

Excerpted from **http://www.recoverymonth.gov/2002/kit/targeted.htm**

The National Clearinghouse for Alcohol and Drug Information
A service of SAMHSA

The cost of addiction to the Nation's health care system tops $114 billion annually.[1] Alcohol and substance abuse and addiction problems are the number one cause of preventable illness and death in the U.S. Whether the eventual manifestation is in the form of infectious disease, cancer, cirrhosis, an accident, or an overdose due to misuse, drug and alcohol addiction is at the root of one in four deaths each year in this country.[2]

Primary care physicians and other health and wellness professionals and practitioners, including nurses, clinicians, wellness movement practitioners, pediatricians, mental health professionals, and social services providers, are the gatekeepers of our healthcare system. For instance, about 70 percent of the population (191 million Americans) see one of the more than 255,000 primary care physicians in the U.S. at least once every two years; 200 million visits are made to general and family practitioners in any given year.[3] The majority of these professionals and practitioners are missing a unique opportunity to identify, intervene on behalf of, refer, and support their patients and clients who may have drug or alcohol problems. Consider these recent findings:[4]

- More than nine in 10 physicians fail to spot a drug or alcohol problem in adults, and more than four in 10 miss a problem in teenagers.

- 94 percent of primary care physicians (excluding pediatricians) fail to include alcohol dependence among the five diagnoses they offer when presented with early symptoms of alcohol addiction in an adult patient.

- 41 percent of pediatricians fail to diagnose a drug problem when presented with a classic description of an adolescent patient with an addiction to drugs.

- Most patients with an alcohol or substance abuse or addiction problem (53.7 percent) say their primary care physician did nothing about their drug or alcohol problem—43 percent say their physician never diagnosed it, and 10.7 percent believe their physician knew about their addiction and did nothing about it.

- Less than one-third of primary care physicians (32.1 percent) carefully screen for the use of or dependence on alcohol or drugs.

Changing the Conversation

To provide an opportunity for the field to reach a working consensus on how best to improve substance abuse treatment and recommend actions that over time could lead to needed change, the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services

Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) launched ***Changing the Conversation: The National Treatment Plan Initiative to Improve Substance Abuse Treatment***. Its primary goal is to ensure that quality drug and alcohol addiction treatment and recovery services and programs are available to all individuals who need them and their family members.

Recommendations about how to affect change have been identified. Health and wellness professionals and practitioners are viewed as invaluable partners when it comes to making progress in the following guidelines for positive action identified by ***Changing the Conversation***:[5]

1. **"No Wrong Door" to Treatment**—Health and wellness professionals and practitioners must ensure that anyone needing substance abuse treatment is identified and provided with treatment, either directly or through appropriate referral.

2. **Commit to Quality**—Effective treatment and the wise use of resources depend upon ongoing improvement in the quality of care.

3. **Build Partnerships**—Individuals and organizations throughout the health field must work together and with outside parties who have a stake in improving substance abuse treatment services.

As a health or wellness professional or practitioner, you are encouraged to think about how you can take action. Any positive steps you take will have a positive effect on the lives of your patients/clients and their families. Here are some ideas to get you started.

Making a Difference: What Can I Do?

1. Know the facts. Physicians and other practitioners are missing or misdiagnosing patient's drug and alcohol problems for several reasons: lack of adequate training in school, residency, or continuing medical education courses; skepticism about treatment effectiveness; discomfort discussing drug and alcohol use and dependence; time constraints; and patient resistance.[6] Ask yourself if any one of these stumbling blocks is impeding you from identifying and helping any of your patients who may be dealing with addiction. In addition, learn all that you can about the nature of addiction and make an effort to understand the recovery process.

There are a number of resources available to assist health and wellness professionals and practitioners in their efforts to learn more. SAMHSA's Center for Substance Abuse Treatment's Treatment Improvement Protocol (TIP) Series #24 contains *A Guide to Substance Abuse Services for Primary Care Clinicians* (DHHS Publication No. (SMA) 97-3139). You can get a copy free of charge by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI) at 1-800-729-6686 or 301-468-2600 or 1-800-487-4889 (TDD). Additional resources, such as the National Institute on Drug Abuse's Clinical Toolbox (Publication No. #CLNBOX), are also available through NCADI. Just ask to speak with one of their trained information specialists to find out more.

2. Seek out additional training. Contrary to how they feel about diagnosing other chronic and manageable diseases like hypertension, diabetes, and depression, only a small percentage of physicians consider themselves "very prepared" to diagnose alcoholism (19.9%), illegal drug use (16.9%), and prescription drug misuse (30.2%).[7] And, where most physicians feel treatment is "very effective" for other chronic conditions, only a few feel treatment is "very effective" for smoking (8.2%), alcoholism (3.6%), and illegal drug dependence (2.1%).

Make efforts to enhance your knowledge and understanding about these issues. Seek out in-service or continuing education opportunities that will enhance your knowledge about the latest scientific breakthroughs. Learn the basics about what to look for in your patients and clients with drug and alcohol problems and how to diagnose, refer, and support them on the path to recovery.

3. Fight your discomfort. Forty-one (40.7%) percent of physicians find it difficult to discuss alcohol problems with patients and 46.6 percent find it difficult to discuss prescription drug misuse, compared to 17.9 percent who find it difficult to discuss depression.[8] Recognize that your discomfort can be a barrier to helping your patients receive adequate care for their addiction.

4. Be extra sensitive to the needs of special populations and those at greatest risk. Ethnic and cultural minorities, individuals with co-occurring mental health disorders or physical disabilities, women, adolescents, to name just a few, may have special needs when it comes to adequately addressing their alcohol or drug problems. Cultural influences, which can include everything from language differences to misperceptions about addiction and the recovery process, can create tremendous barriers to individuals from these populations getting help. In addition, studies show that a silent epidemic of alcohol and prescription drug dependence is developing among the nation's elderly. Women over the age of 60 seem to be at particular risk.[9] New studies show that adolescent alcohol dependence may damage brain function[10] and that teen drinkers show signs of liver damage.[11] Health and wellness professionals and practitioners need to be alert to these issues and make an effort to be sensitive in identifying and dealing with these groups.

Making a Difference: How Can I Focus My Efforts? As a health and wellness professional or practitioner, we encourage you to think about what action steps you can take in anticipation of or during this year's month-long effort to further your own related goals and those of ***Changing the Conversation***. Here are some thoughts for your consideration:

1. Provide in-service education. Work with your local medical society or professional groups to host an in-service education breakfast or meeting during the month of September. Invite outside experts to inform your staff about identifying, assessing, referring, and supporting patients or clients with drug or alcohol problems.

2. Make screening and brief intervention standard. Relatively few health and wellness professionals and practitioners make screening and intervention for drug and alcohol problems an integral part of their practice when both can be undertaken in a relatively brief period of time, and have been shown to be effective. Guidance on how to screen and conduct a brief intervention is available from many sources, such as the HHS/SAMHSA Center for Substance Abuse Treatment's Treatment Improvement Protocol (TIP) Series #24, which contains *A Guide to Substance Abuse Services for Primary Care Clinicians* (DHHS Publication No. (SMA) 97-3139). Your professional association may also have materials available for you on this topic.

3. Make time. One-third (35.1%) of physicians say time constraints keep them from discussing drug and alcohol problems with their patients, and 35 percent (35.3%) of patients with alcohol and substance abuse problems thought their physician was too busy to detect their addiction.[12] Health care professionals often are overwhelmed by the ever-increasing demands on their time, and managed care has imposed even greater time constraints. However, a conversation with a person who you suspect may have an addiction problem may be enough to identify the problem and start the patient on the road to recovery.

4. Speak out. As someone who deals with health and wellness issues every day, you have clout—with your patients and clients, their loved ones, and the community at large. What you have to say about the issues of drug and alcohol dependence and recovery does matter. Speak out during ***Recovery Month*** and throughout the year. Participate in a Community Forum if you are asked, or volunteer to do so. Facilitate partnerships with key community stakeholders to enhance the continuum and availability of drug and alcohol addiction treatment and recovery programs and services in your area. And, take every opportunity to reinforce the fact that addiction is a chronic medical condition for which treatment can be effective.

Sources

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12 Missed Opportunity

The National Clearinghouse for Alcohol and Drug Information
A service of SAMHSA

AODA Treatment for People with Disabilities

Brief Summary

TITLE:
Substance use disorder treatment for people with physical and cognitive disabilities.

SOURCE(S):
Substance Abuse and Mental Health Services Administration (SAMHSA). Substance use disorder treatment for people with physical and cognitive disabilities. Rockville (MD): U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment; 1998. 171 p. (Treatment improvement protocol (TIP) series; no. 29). [101 references]

ADAPTATION:
Not applicable: Guideline was not adapted from another source.

RELEASE DATE:
1998

MAJOR RECOMMENDATIONS:
Recommendations that are supported by research literature or legislation (i.e., the Americans with Disability Act [ADA]) are followed by a (1); clinically based recommendations are marked (2).

Making Accommodations to a Program

- Providers should examine their programs and modify them to eliminate four fundamental groups of barriers to treatment for persons with disabilities: attitudinal barriers; discriminatory policies, practices, and procedures; communications barriers; and architectural barriers. **(1)**

- *Accommodation* does not mean giving special preferences--it does mean reducing barriers to equal participation in the program. **(1)**

- When barriers cannot readily be removed, a program must find alternative methods to make its services available. **(1)**

- Staff training is key to overcoming most barriers to treatment, especially attitudinal barriers. Such training should be ongoing and comprehensive. All program staff should be trained in understanding functional limitations, the wide variety of conditions that lead to them, and the barriers that treatment-as-usual might present for persons with specific disabilities. Training should strongly encourage and reward staff members who find creative ways to adapt treatment procedures for people with coexisting disabilities. Because they are the initial points of contact, receptionists and other support staff should receive special training to prepare them to respond knowledgeably and sensitively to people with coexisting disabilities. **(2)**

- If there is any doubt on the part of the provider regarding the legitimacy of a person's request for accommodation, a disability expert should be consulted to evaluate the request. **(2)**

- In general, it is beneficial and feasible to integrate people with coexisting disabilities into already existing community-based services used by nondisabled individuals recovering from substance use disorders. However, there are a number of exceptions to this rule. In instances where a legitimate, documented reason exists, specialized services may be necessary. **(2)**

- For clients who are blind or visually impaired, keep pathways clear and raise low-hanging signs or lights. Use large letter signs and add Braille labels to all signs and elevator buttons. Make oral announcements; do not rely on a bulletin board. **(2)**

- People who are blind or visually impaired will require assistance to orient themselves to a new environment. The treatment provider should give clients who are blind a complete orientation to the facility the first time they visit; the client can be guided by holding her arm just above the elbow and walking with her through the rooms, explaining where the doors, furniture, and other features are. **(2)**

Screening for Disabilities

- Because many disabilities are not obvious, it is important to screen for them in every person, not just those with obvious functional limitations. Ask all clients entering treatment whether they require any accommodations in order to participate. **(2)**

- It is the level of abilities and of the functioning of the individual--not the simple determination of whether an impairment exists--that must be assessed if screening is to lead to an effective treatment plan. In situations where a diagnosis of disability is needed (e.g., to qualify for special services) treatment providers should refer the client to a disabilities services professional. **(2)**

- Although it is a good idea to get background information from as many sources as possible, interview the person alone, if possible. Having others present often distorts the quality of the interview. **(2)**

- Intake interviews should begin with an open and friendly question, not one that is focused on the person's disability. **(2)**

- An intake interview should address the eye condition and blindness adjustment skills of people who are blind or visually impaired. The counselor should ascertain the pathology of the loss of vision (if it was congenital, adventitious, or traumatic), and precisely how much vision remains. **(2)**

- If there are forms to be completed as part of intake processing, people who are blind must have the option to complete them in the medium of their choice (Braille, large print, audiocassette, or sighted assistance). Individuals who are both deaf and blind will need a tactile interpreter to translate for them during the admissions process and afterward. **(2)**

- Due to the wide range of reading abilities among people who are deaf, paper and pencil should never be utilized to gather detailed assessment information. Written English forms and questionnaires should be interpreted into sign language for these clients. **(2)**

- When screening people with cognitive disabilities, be as specific as possible--rather than asking if they "use alcohol," ask if they like to drink beer, wine, wine coolers, etc. It may help to use props such as different glass or bottle sizes rather than asking how many ounces were consumed. **(2)**

Treatment Planning

- For treatment to succeed, all clients must understand the particular strengths that they can bring to the recovery process. A strengths-based approach to treatment is especially important for people with disabilities, who, because they have so frequently been viewed in terms of what they cannot or should not attempt, may have learned to define themselves in terms of their limitations and inabilities. **(2)**

- It is key to the treatment planning process for the treatment provider to learn where a person with a disability is on the spectrum of understanding and accepting his disability. **(2)**

- No treatment plan should be static, and treatment providers must continually evaluate and revise the treatment plan with assistance from clients with disabilities. Treatment plans should be flexible enough to take into account changes in a person's condition or new knowledge gained during treatment. Clients with traumatic brain injury, for example, often show a dramatic recovery curve over the year to two years following their accidents. **(2)**

- An individual with a disability may also need to explore several methods for learning something or fulfilling a goal before an accomplishable approach to the situation can be identified and implemented. **(2)**

- The treatment plan should document all alterations to the usual treatment procedures that are being made. If an approach does not work, the outcome should still be carefully documented to prevent duplication of effort by other programs in the future. Similarly, details of what is successful for a person should be documented, particularly for persons with cognitive disabilities who may not be able to tell future caregivers which treatments have been effective and why. **(2)** Documentation of all efforts at accommodation is needed to verify ADA compliance. **(1)**

- It is helpful to identify early on any needed exceptions to the routines of the treatment program for a person with a disability and to explain to other clients that the accommodations for a person with a disability simply give her the help she needs to meet shared goals. If the client does not object, the exceptions and the rationale for these exceptions should be discussed openly in group meetings. **(2)**

- Behavioral contracts with people with coexisting disabilities may need to be more explicit than those with other people, and the consequences for relapses in particular may need to be specifically tailored to what the individual is realistically capable of achieving. **(2)**

- People who are deaf or hard of hearing (and probably those with other disabilities as well) generally know less about addiction and recovery when they enter treatment than nondeaf (or nondisabled) people, and therefore they will often require lengthier treatment. Treatment providers should be prepared to allow for longer treatment times for clients with disabilities. **(1)**

- It is essential that all clients participate in planning leisure activities, and programs with rigid approaches that exclude clients from such participation should consider changing their policies. **(2)**

- If a person with a disability has limited transportation options, conduct individual counseling by telephone, go to the person's house, or meet at a rehabilitation center or other alternative site. The Consensus Panel recommends that providers make home visits if necessary, which may be reimbursable under case management services. **(2)**

- For people with coexisting disabilities, failure to achieve treatment goals may indicate that the treatment plan lacks the discrete steps necessary to meet those goals. In setting a goal, the client and the counselor must work closely to understand all the physical and cognitive requirements of meeting a goal. **(2)**

- Early in treatment, a medical professional should conduct an assessment of all the client's medications--both prescribed and over-the-counter, including herbs and vitamins. In addition, the Panel recommends that a single medical professional try to monitor the client's medication regimen. Under no circumstances, however, should other treatment staff advise clients to take or not to take particular medications, vitamins, or herbs. **(2)**

- Lack of employment may be a factor in substance abuse; conversely, addressing and overcoming barriers to employment, with the aid of collaborative partners, may greatly enhance the prospect for recovery and should be addressed as a component of treatment planning. **(2)**

Counseling

- Counseling session times should be flexible, so that sessions can be shortened, lengthened, or more frequent, depending upon the individual treatment plan. **(2)**

- For people with cognitive impairments, it is important to remember to ask simple questions; to repeat questions; and to ask the client to repeat, in her own words, what has been said. Discussions should be kept concrete. People with mental retardation or traumatic brain injury may not understand abstract concepts; they should be asked to provide specific examples of a general principle. **(2)**

- The use of verbal and nonverbal cues will help increase participation and learning for people with cognitive disabilities and make the group sessions run more smoothly for all. The counselor and the person with a disability together can design the cues but should keep them simple, such as touching the person's leg and saying a code word (e.g., "interrupting"). **(2)**

- Clients with cognitive disabilities will often benefit from techniques such as expressive therapy or role-playing. **(2)**

- Assignments that require the use of alternative media in place of writing may work best with clients who have cognitive disabilities as well as those who are deaf. **(2)** Clients who are blind will need assignments translated into their preferred method of communication (e.g., Braille, audiotape), but no matter what method is used they will require more time to complete reading assignments**. (1)**

- Regardless of the model of communication used by the person who is deaf or hard of hearing, the visual aspect of communication will be important. Therefore, it is important to look directly at the person when communicating. This will allow him to try to read the lips of the counselor and to see her facial expression. **(2)**

- Interpreters should usually be provided for people who are deaf or hard of hearing. **(1)** The interpreter should be a neutral third party hired specifically to interpret for the counselor and the person who is deaf; a family member or friend of the client should not be used as an interpreter. Use only qualified interpreters as determined by either a chapter of the Registry of Interpreters for the Deaf or a State interpreter screening organization. **(2)**

- If a person who is deaf is using an interpreter, group members will need to take turns during discussions. When addressing a person who is deaf the counselor or group members should speak directly to the person as if the interpreter is not present. **(2)**

- When working with an individual with a physical disability, make certain that table surfaces are the correct height, and in particular that wheelchairs can fit beneath them. Counselors should try to place themselves so that they are no higher than the client. They should be aware of the pace of the interview, and attempt to gauge when clients are becoming fatigued. Counselors should periodically inquire how the client is doing and offer frequent breaks. **(2)**

- People who use wheelchairs often come to regard the chair as an extension of themselves, and touching the chair may be offensive to them. Never take control of the wheelchair and push the person without permission**. (2)**

- For individuals with cognitive disabilities, providers must systematically address what has been learned in the program and how it will be applicable in the next stage of treatment or aftercare. Some people are very context-bound in their learning, and providers cannot assume that the lessons learned in treatment will be applied in aftercare. **(2)**

- In planning and providing treatment to people with disabilities, the importance of asking questions cannot be overemphasized. Asking before rendering any service is a basic principle. **(2)**

Linkages

- Coordination with an agency providing case management services for people with disabilities should be a priority if those services are not already being provided by the substance use disorder treatment program. Treatment plans for people with coexisting disabilities should address problems such as unemployment, a lack of recreational options, social isolation, and physical abuse because they are more likely than the general population to experience these situations. **(2)**

- Service linkages are essential to provide effective substance use disorder treatment for people with coexisting disabilities. **(2)**

- Treatment providers need to be able to identify what ancillary services are available for their clients, and be able to access those services and funding sources. **(2)**

- Since a client having a substance use disorder and a disability may also be in a physical rehabilitation or other disability program, treatment professionals should be aware of the various approaches used by these other programs, and know how to collaborate with them. The Panel recommends cross-training between vocational rehabilitation or other disability service providers and substance use disorder treatment providers to help treatment professionals understand the impacts of both disability and substance use disorders. **(2)**

- In developing partnerships with referring agencies, the treatment program should ensure, through interagency agreements, that mechanisms are in place for exchanging client information. **(2)**

- It is not unusual for services to be duplicated or ineffective when a case manager is not utilized, and so a substance use disorder treatment provider may need to either case manage these services or find another organization or person to do so. A case manager can be a strong advocate for a person with a disability and help her locate appropriate and accessible services. **(2)**

- A substance abuse counselor may not have the time or the expertise to work on all the issues that arise because of a client's disability. If that is the case, a referral to a peer counselor at a Center for Independent Living, whose job it is to help disabled individuals come to terms with the limits of their disabilities, may be in order. The two counselors can work together as a team. **(2)**

- The treatment provider should investigate whether accommodations will be made for a client with a coexisting disability before sending him to an aftercare facility. **(2)**

Organizational Commitment

- Providers must be prepared to act as advocates for their clients when services and supports that are normally readily available and effective prove inaccessible for the client. **(2)**

- When treatment teams make the effort to accommodate individuals with coexisting disabilities, the quality of care improves for all clients. All clients can get more out of treatment that is individualized and that takes their specific functional capacities and limitations into account. **(2)**

- To ensure full organizational support for treating people with coexisting disabilities, the Consensus Panel recommends that a treatment program develop a policy statement that articulates the program's willingness to accommodate any individual with a disability who chooses to attend the program. **(2)**

- When a program makes a commitment to serving people with coexisting disabilities, board membership of people with disabilities may be implemented immediately or considered as a goal to be reached as the program begins to serve a greater number of people from these groups. A program should try to obtain regular input from the community it seeks to serve;

creating a permanent task force or an advisory committee is an ideal way to address this need. **(2)**

- The organization must make a commitment to continually reexamine the program's effectiveness for people with coexisting disabilities. Such inquiry can take place both formally, using quality assurance methods and consumer satisfaction surveys, and informally, through opportunities for individual and group feedback with program staff**. (2)**

- It is not enough for a program simply to be ready to serve people with coexisting disabilities. Rather, the program should be proactive in making the disability community aware of its services to ensure that disability organizations will support referrals to the program. **(2)**

- Another sign of organizational commitment is to hire people with disabilities to work in the treatment program. Hiring people with disabilities also benefits other staff members, who can learn from these coworkers. **(2)**

- The Consensus Panel recommends an "open door" policy that states that all clients are entitled to an assessment if they are presenting with a chemical dependency problem, regardless of whatever other problems they may appear to have. If the proper course of treatment is not available at the facility, it is still possible to perform a substance use disorder assessment and refer the client for treatment elsewhere. **(2)**

Improving Treatment for All Clients

Treatment that is planned and provided on a case-by-case basis will benefit everyone, not just those clients with coexisting disabilities. All people have different functional capacities and limitations, and an evaluation of these, as described and encouraged in the original TIP, will help providers focus on individual needs. The original TIP explores the treatment needs of people with particular types of disabilities, but the processes of assessment and evaluation it suggests can help all clients gain greater benefit from treatment.

There is a growing belief in the substance use disorder treatment field that treatment is more successful if it can respond to all the needs of an individual, not just the need to stay away from alcohol and drugs. If treatment is to succeed for a client with a coexisting disability, a wide range of services may be required. For this reason, the original TIP strongly encourages the use of case management services and service linkages. The original TIP also aims to educate people in both the disability services and substance use disorder treatment fields concerning the problems faced by people who have both a substance use disorder and a coexisting disability. A better understanding of the needs of these clients and the services available to them can be gained through reading the original TIP.

COMMITTEE: Treatment Improvement Protocol Series 29 Consensus Panel

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GUIDELINE AVAILABILITY:

Electronic copies: Available from the National Library of Medicine (NLM) Health Services Technology Assessment Text (HSTAT) database. Publications may be ordered from NCADI's Web site or by calling (800) 729-6686

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